S. Hrg. 102-84, Pt. 1

HEALTH CARE COSTS AND LACK OF ACCESS TO HEALTH INSURANCE

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

APRIL 9 AND 16, 1991

(Part 1 of 2)

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

43-866 - - WASHINGTON : 1991

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

COMMITTEE ON FINANCE

LLOYD BENTSEN, Texas, *Chairman*

DANIEL PATRICK MOYNIHAN, New York
MAX BAUCUS, Montana
DAVID L. BOREN, Oklahoma
BILL BRADLEY, New Jersey
GEORGE J. MITCHELL, Maine
DAVID PRYOR, Arkansas
DONALD W. RIEGLE, Jr., Michigan
JOHN D. ROCKEFELLER IV, West Virginia
TOM DASCHLE, South Dakota
JOHN BREAUX, Louisiana

BOB PACKWOOD, Oregon
BOB DOLE, Kansas
WILLIAM V. ROTH, Jr., Delaware
JOHN C. DANFORTH, Missouri
JOHN H. CHAFEE, Rhode Island
DAVE DURENBERGER, Minnesota
STEVE SYMMS, Idaho
CHARLES E. GRASSLEY, Iowa

Vanda B. McMurtry, *Staff Director and Chief Counsel*
Edmund J. Mihalski, *Minority Chief of Staff*

CONTENTS

ADMINISTRATION WITNESS

PUBLIC WITNESSES

ALPHABETICAL LISTING AND APPENDIX MATERIAL SUBMITTED

COMMUNICATIONS

HEALTH CARE COSTS AND LACK OF ACCESS TO HEALTH INSURANCE

TUESDAY, APRIL 9, 1991

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:02 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Lloyd Bentsen (chairman of the committee) presiding.

Also present: Senators Mitchell, Pryor, Rockefeller, Daschle, Breaux, Packwood, Danforth, Durenberger, Symms, and Grassley.

[The press release announcing the hearing follows:]

[Press Release No. H-10, March 25, 1991]

FINANCE COMMITTEE PLANS HEARINGS ON HEALTH CARE COSTS; SENATOR BENTSEN CONCERNED ABOUT RISING COSTS AND LACK OF ACCESS

WASHINGTON, DC—Senator Lloyd Bentsen (D., Texas), Chairman of the Senate Finance Committee, Monday announced hearings on the twin problems of rising health care costs and lack of access to health insurance.

The hearings will be at *10 a.m. on Tuesday, April 9 and Tuesday, April 16, 1991* in Room SD-215 of the Dirksen Senate Office Building.

"Too many people—more than 39 million Americans, including 9 million children—don't have any health insurance. Many of these uninsured people have jobs but they work for small businesses, which themselves face a number of barriers to providing insurance for employees. Many employers are unable to get coverage for small numbers of workers or, when they can, the premiums are enormously high," Bentsen said.

"In recent years, the Finance Committee has taken important steps to expand access to health services and make Medicare and Medicaid more cost effective. We've broadened Medicaid eligibility, instituted innovations in government insurance programs such as Medicare and Medicaid and improved access to these and other health care programs while controlling growth in spending. Yet despite the important steps Congress has taken to address the difficulties of families who can't afford or lack access to health care, these problems remain," Bentsen said.

"These hearings will explore the causes of rising costs and lack of access to health care and possible strategies for resolving these problems. Any solution will require a cooperative effort between the public and private sectors," Bentsen said.

OPENING STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM TEXAS, CHAIRMAN, SENATE FINANCE COMMITTEE

The CHAIRMAN. If you will, please be seated and cease conversation.

This morning is the first meeting of this committee after the tragic death of our good friend and colleague Senator John Heinz. I know that all the members of this committee are going to sorely miss him, as will his friends, but also the millions of Americans in whose interest he so vigorously worked.

In the last few months John was deeply involved in some of the tough issues facing this country. One of those was working on the famed "fire wall" with Senator Moynihan and other members of this committee, to protect budget invasions of the Social Security Trust Fund.

Another was extending home care to the most frail of dialysis patients; and, of course, serving as the ranking member of the Aging Committee and as a member of the Pepper Commission, where he demonstrated his intense commitment to health care provision for the elderly, the disabled, and their families.

I think John would be pleased to know that we are launching into some of the tough problems with health care facing the American people and their elected officials, access to affordable health care for the millions of Americans who lack insurance coverage.

He was a good friend, he was an able Senator, and we are going to miss him.

Senator Packwood, would you care to comment?

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON

Senator PACKWOOD. Mr. Chairman, I echo those sentiments.

I know this hearing has been scheduled for some period of time, but it is ironic, of all the subjects we deal with, this is the one that John would have been at and would have spent most of his time on. What he has brought to this committee and what he knew about this subject is not going to be easily replaced by anyone, no matter how long they serve on this committee.

There is not much more I can say, except we have lost a good friend and an able member.

The CHAIRMAN. I know all the members of the committee share in that.

Senator PACKWOOD. Could I say just a couple more things, if I might, because this is the start of a number of hearings we are going to have on this subject. Here is what I have discovered—I guess we get it more by anecdotal evidence than otherwise.

As I go around the State, I get very few questions from employees of businesses that have a health insurance plan; they seem reasonably satisfied with their plan. It is where there is no plan, or where you have self-employed—who, if they are making $40,000 to $50,000 a year, taxes are very high for them, anyway—there I find more problems.

There are two areas where the problems exist: one is the coverage, and the other is the cost, and in some cases the inability to buy the insurance at all.

Oregon has taken several steps to try to resolve many of the problems that face those who currently have no adequate insurance. And all of these steps or laws were enacted by the last session of the legislature, and they come into effect gradually over the next 3 years. They will be in full effect by 1994. I hope the Congress will help us carry it out.

One is Oregon extended Medicaid coverage to all of those at the poverty level or below—most States do not cover Medicaid to that level;

Two, we passed a law mandating health coverage by all employers; and

Three, for those who are simply medically uninsurable, and there are 20,000 such people in Oregon, we have set up a fund which will help cover their health insurance premiums.

The upshot of this is, by the middle of 1994 about 98 percent of all Oregonians will have coverage in one form or another.

We need some help from Congress in the way of waivers to try this program, but I am hoping that the Congress will be receptive to a rather innovative approach by one State and will give us the chance to try some things that might be of help to other States and to private carriers, who are tremendously concerned about the spiralling costs.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Today we begin a series of hearings in the Finance Committee on two facets of this health care problem. One is the access to health insurance, and the other is the affordability of health care.

The United States spends more on health care than any other country in the world, and yet we have over 30 million Americans without health insurance. Nine million of those are children.

Polls taken last year show that the American people are more concerned about health care than they are about taxes, or interest rates, or, for most of them, even about losing their jobs. No wonder.

The Department of Commerce says that health care costs have increased from $249 billion in 1980 to $675 billion in 1990. Those increasing costs affect all purchasers, whether it is government, business, workers, or other individuals.

I had a letter from a Texas preacher the other day. He was talking about the increase in health care costs. He said he had budgeted for the church a premium that was approximately 40 percent above what it had been the year before. He said they had a $200 deductible, and their medical costs had not exceeded the deductible. But he said when he budgeted it, he thought he was certainly taking care of inflation; but by the time the premium came in for the renewal of the policy, it was far, far above what had happened to inflation.

He said, "What's happening in the country—we have some of the best health care in the world, and it is there for those who can afford it. And for the poor? They are taken care of by Medicaid." "But," he said, "middle income America is in a real squeeze.

And you are running into small businesses that see health care now as over a quarter of their costs of doing business. First they drop the dependents, and then they increase the deductible, and finally they drop the policy altogether.

So it is an incredible problem facing us.

Employer-based health insurance accounts for almost one-third of all national spending on health care. A survey of chief executives from Fortune-500 companies, published yesterday in "Health Affairs," indicates that health care costs were a major worry for virtually all of them.

According to a survey by the National Federation of Independent Businesses, two-thirds of small business owners believe the cost of health insurance is a serious business problem.

The cost of health care compounds the problems of the uninsured. Where do they go? They go to the emergency room of the hospital. And most of those bills aren't paid, or they are charged to "charity," then passed on to the other patients of that hospital, increasing their health care costs.

We can be certain that any comprehensive solution to the dual problems of increasing health care costs and the lack of universal access to health insurance is going to require a concerted best effort, whether we are talking about employers, government, or individuals.

So that is what we are going to be seeking guidance on from the witnesses that we have here today, people with differing perspectives.

In May of last year I asked the Congressional Budget Office to study the factors that are making health care costs more costly, analyze the success of strategies used by the private sector and by government—and governments like your own State that you were citing, Senator Packwood. I am pleased that Bob Reischauer, who is the Director of CBO, is here today to discuss that report.

We are also going to be hearing from other distinguished witnesses: Lane Kirkland, President of the AFL–CIO, who will discuss labor's perspective on health care costs and access to insurance; Bob Blendon, of Harvard University, has studied public attitudes about the health care system, and hopefully he will be able to enlighten us about what steps, if any, the American people are willing to face up to, to try and resolve this problem.

Our final panel is an impressive group of business leaders from large firms, and some small ones, too, who wrestle with these problems every day. As we seek to develop effective initiatives, the guidance of all of these witnesses is going to be helpful to us.

Did you have any further comments, Senator Packwood?

Senator PACKWOOD. No, Mr. Chairman.

The CHAIRMAN. Senator Rockefeller?

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Mr. Chairman, just to briefly add on to what you said.

First of all, the loss of John Heinz. He would have been all over this subject, with intensity, persistence, not letting up when his time had run out because he hadn't finished his questioning. He was very, very bright, extremely knowledgeable, and you feel—this is sort of the first day in the Senate session, so to speak, that you really feel the absence of Senator Heinz. I think we are all conscious of it.

What I hope comes out of these hearings is not just a lament about the health care crisis and the definition of it. I hope we can try to work toward some solutions.

You mentioned the cost to business. Currently, the average cost per employee for health benefits in America is about $3,200. At the rate that we are now going, if nothing is done by the year 2000, that average will increase to $22,000 per employee, just for health care benefits.

Cost containment is an absolutely fundamental subject that has to be addressed. In the last several months I have discovered that many of the groups that I have met with talk about the importance of cost containment. But when you get down to specific suggestions of ideas, they find it a little more difficult to agree with the specifics.

I think it is really important for us to understand that the health care crisis is no longer a matter of the poor. I think it has been seen that way—the so-called "uninsured poor" and the "semi-poor." It is a middle class issue. It is a family issue; it is a State and local government issue; it is a Federal issue; it is a small business issue; it is a big business issue.

I think that the system is in the process of "imploding," so to speak, simply falling in on itself, and I really hope that these hearings start to get at solutions for access and solutions for cost containment.

I thank the Chairman.

The CHAIRMAN. Thank you.

Senator Durenberger?

OPENING STATEMENT OF HON. DAVE DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Mr. Chairman, just briefly, thank you for beginning this series of hearings, and thank you for taking a comprehensive approach. Thank you for starting with Bob Reischauer and Bob Blendon, and helping us outline the problem. It occurs to me that, until all of us can see the problem the same way, we aren't going to come up with a solution.

Separately, it is hard for me to express how I feel sitting next to an empty chair.

I think all of us learned from John Heinz. He spent enough time on the problems so that we knew what they were, and then he went immediately to the solutions.

As Jay has said, it may have taken him a little more than 5 minutes sometimes, but he never asserted that we had a problem without also offering a solution to it. Or maybe he offered a couple of solutions, and we got to pick. But he usually had picked one of those, and he was willing to sit here and fight for it.

So, as we begin by looking at the problem and trying to reach agreement on the problem, I endorse what Jay Rockefeller said. I hope, by the end of these four or five hearings, we are also agreed on some solutions, because that is what John would have wanted us to do.

The CHAIRMAN. Thank you.

Senator Breaux?

OPENING STATEMENT OF HON. JOHN BREAUX, A U.S. SENATOR FROM LOUISIANA

Senator BREAUX. Thank you, Mr. Chairman, for, number one, convening these hearings.

I also echo the sentiments expressed about our good friend on this committee and other committees in the Senate, and a good friend of mine in other areas in addition to the Congress.

We were tennis-playing opponents on a regular basis, and John's competitive spirit not only was within the Congress but also on the courts and on the athletic field. Those are some of the fond memories, certainly, that I am going to share, from having known him. He is going to be a real loss to this Congress, and particularly to the Senate and to this committee.

Mr. Chairman, I think these hearings are incredibly important. I think America really is on a collision course between the high cost of health care in this country and the public's demand for better and better services.

I am reminded of the story about the guy who goes to see the doctor and orders a whole battery of tests, and the doctor says, "It's going to be very expensive." The patient says, "Money is no object. I have none."

We are finding that by the polls that we see. People want more and more health care, and they want better health care, and we are getting all of that; but we are facing an inability to pay the price. How we resolve that problem certainly is not to produce less health care, but to figure out how to pay for it.

Hopefully, these hearings will be the beginning of an answer to what I think is the most serious problem facing this Congress and our government in the next decade. I think these hearings are the first step in helping to solve that problem, and I thank the Chairman for convening them.

The CHAIRMAN. Thank you.

Senator Daschle?

Senator DASCHLE. I have no statement, Mr. Chairman.

The CHAIRMAN. All right.

Well, Senator Rockefeller, you are quite right. As the Chairman of the committee, John often ran over his time, and he felt strongly about issues. Unfortunately, John's time ran out again, when he had so much to do, so much he wanted to do. But he leaves a very proud record.

I must say, in visiting with Teresa, his wife, she talked about his enthusiasm and his love for this committee and its work and its objectives.

Senator Grassley? I did not see you come in.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. Mr. Chairman, thank you very much.

I had the opportunity of serving with John Heinz on the Aging Committee for my entire period of time in the U.S. Senate, and of course just 6 years here with him on the Finance Committee.

But whether it was on the Finance Committee or on the Committee on Aging, particularly for a committee issue like we are involved with now, health care, and the cost of health care, and reforming health care, everybody knows that he would be in the middle of that debate and contributing very much to that debate.

Obviously, the Congress and the country as a whole will suffer because the contributions that he would have made are not going to be there in the debate now. I think it will make it more difficult

to reach agreements that could be reached. So, we are all going to miss him.

Mr. Chairman, on the issue before us today, it seems to me that it is a very, very difficult issue, because what Americans want in health care is the very best health care and they do not want to pay anything for it.

To go from where we are now to where people want to go, obviously will be very difficult; we may never get there. Bringing reform to the system that we have now, and covering 37 million Americans that don't have health care coverage, and doing it within our means and satisfying the public at the same time, is going to be an almost impossible job politically.

The only way it is going to come about is if we enhance public understanding of the problem through dialogue. Of course, your committee hearings today are a very important step towards that end.

I not only encourage you to help bring national attention to just the issue, but to encourage through your leadership the broadest possible grass roots discussion and understanding of the issue of health care reform, because we have got to have more of a consensus than we have now if we are ever going to bring about needed changes.

Thank you.

The CHAIRMAN. Senator Mitchell?

STATEMENT OF HON. GEORGE J. MITCHELL, A U.S. SENATOR FROM MAINE

Senator MITCHELL. Mr. Chairman, thank you very much.

I want to begin by commending you for scheduling the hearing today to examine the rapidly rising cost of health care and the problem in assuring that all Americans have access to care. I think it is a critical issue facing our society, and I know that you are prepared to deal with it forthrightly and responsibly. I look forward to joining you in that effort.

I ask unanimous consent, Mr. Chairman, that the full text of a statement I have be placed in the record.

The CHAIRMAN. Yes, of course.

Senator MITCHELL. I think that access to affordable quality health care should be a right for all Americans. But as we are all aware, not all Americans have access to such care. Our task must be to see that they do.

There are a great many problems confronting us in this area. It is essential that those 37-or-so million Americans who don't have health insurance do have it. It is essential that costs be contained. It is essential that we devise a policy to deal with the problems of long term care for our elderly.

Those are all immense tasks to which this committee will, I know, address itself, and I look forward to participating in that effort.

I would like to join my other colleagues in expressing my regrets at the passing of our colleague Senator Heinz. He will be missed in many respects, perhaps none greater than this: He was devoted to the problems of the elderly, as we know, and the problems of

health care. All of us who worked closely with him on those problems over the years know of his vigor and active involvement in those issues, and we deeply regret his loss.

The best thing we can do is to pass a meaningful health care reform bill that will embody the concepts that he would have favored.

Thank you, Mr. Chairman.

[The prepared statement of Senator Mitchell appears in the appendix.]

The CHAIRMAN. Well, Mr. Majority Leader, with the many demands on your time, for you to be here attending these hearings shows how strongly you feel about the issues and your deep involvement. We are pleased to have you.

Senator Dole.

OPENING STATEMENT OF HON. BOB DOLE, A U.S. SENATOR FROM KANSAS

Senator DOLE. Mr. Chairman, along with you and the other members of this committee, I want to express my sadness at the death of our colleague, John Heinz.

John was a truly remarkable public servant. When many in his circumstances would have spent their life making more money, he chose, instead, to make a difference. And what a difference he made for the people of Pennsylvania and America.

As chairman of this committee for 4 years, I counted on John's wisdom and his willingness to tackle the tough issues of the day—traits I also relied upon these past 6 years as Republican Leader.

John was a "Senator's Senator." Hard working, intelligent, fair, and devoted to the highest standards of integrity. I was proud to call him my colleague, and prouder still to call him my friend.

I join with all Senators in extending our deepest sympathies to Teresa, and to their sons, John, Andre, and Christopher.

The CHAIRMAN. Dr. Reischauer, if you would proceed.

STATEMENT OF DR. ROBERT D. REISCHAUER, DIRECTOR, CONGRESSIONAL BUDGET OFFICE

Dr. REISCHAUER. Thank you, Mr. Chairman. I would like to add my voice to yours and to those of the other members of this committee with respect to the loss of Senator Heinz.

Senator Heinz had an insatiable appetite for CBO cost estimates and CBO analyses. He used those estimates and those analyses; he didn't misuse them. He was an excellent customer who respected our independence and our nonpartisan status.

He did ask good questions, as Senator Rockefeller said, and he asked many good questions. I remember the last time I had the opportunity of testifying before Senator Heinz, at the Banking Committee just several weeks ago. We went through one round of questions, and a second round, and a third round. The other members had left, and people had begun eating lunch. When they finished eating lunch, Senator Heinz was still asking me questions. He was interested in the answers. He wasn't interested in scoring points.

He was a Senator whom both I and the Congressional Budget Office will miss—a good customer, as I said.

With your permission, I will submit my prepared statement for the record.

The CHAIRMAN. Without objection, that will be done.

Dr. REISCHAUER. What I would like to do is to limit my remarks, first, to a summary description of the problem and the causes of high and escalating health care costs in this country; and, second, to make some observations about the effectiveness of the various strategies that we have pursued as a nation over the last several decades in trying to achieve greater control of health care costs.

Whether one measures health care costs on a per capita basis or relative to the size of our economy, the United States spends much more on health care than does any other industrialized nation. The differentials between the United States and those other industrialized nations have increased rather significantly over the last quarter of a century, particularly over the last decade.

Given my position, I would be remiss if I didn't point out that this increasing spending on health care has had very important ramifications for our Federal budget.

In 1980, 11 percent of the Federal budget was devoted to health spending; by 1990, the last fiscal year we have completed, that figure had reached about 14 percent. If current trends continue, in other words if the trends follow the projections of the Congressional Budget Office under the baseline methodology, taking account of the budget agreement that was hammered out last fall, by 1996 almost 20 percent of our budget will be devoted to health care. In other words, in a period of 16 or 17 health-related spending will have risen 11 percent to 19.5 percent of the budget.

Many factors have contributed to the high and rapidly rising cost of health care in America. However, the major explanation is probably the failure of the normal discipline of the marketplace to limit the quantity and quality of services that are supplied and consumed.

This failure, which in many ways is really unavoidable, has come about for two reasons: The first of these is that much health spending is paid for by insurance. This means that the consumers pay less than the full price for the services they purchase, and therefore are encouraged to demand more than they would in the absence of insurance.

The development of extensive insurance is quite understandable considering the great degree of uncertainty that surrounds a person's need for medical care, and also considering the high cost of that care when it is received.

The second reason why the discipline of the marketplace has failed is that consumers have delegated much of the decisionmaking in health care services to the providers.

It is not at all surprising that the consumer has delegated decisionmaking to the providers, considering the complexity of the decisions that are involved, the rapid technological changes that are taking place in the provision of medical care, and the uncertainty that surrounds the efficacy of certain treatments.

Of course, other factors have contributed to the high level and rapid increase in health care spending in this country. Let me just tick off for you five of these contributing factors:

The first is demographic—namely, the aging of our population.

A second factor is the tax incentives that we have provided for employer-based group insurance policies, leading to what might be regarded by economists as an "over-consumption of insurance."

A third factor is the administrative complexity of our system. We have a great number of payers, and many of them are paying a different price for the same service from the same provider.

A fourth factor contributing to high and escalating health care costs in this country is the unrestrained development and dissemination of expensive new medical technologies.

A fifth is the medical malpractice environment, which has encouraged the practice of defensive medicine, pushing up costs.

Finally, there is the high value that Americans place both on having a choice of providers and on receiving prompt care. What this means is that we have to maintain a certain degree of excess capacity in our system, and the maintenance of excess capacity is expensive.

During the last two decades, a number of strategies have been pursued in an effort to control costs, to damp down the rate of increase of health care spending in this country. While these efforts do not seem to have done much to restrain the overall growth of spending, we have learned something from the experience.

What I would like to do with you is to share our judgments about the effectiveness of five of the major strategies that have been pursued.

The bottom line in this review is really that there are no silver bullets; none of these strategies has been able to slay the dragon.

The first strategy we have tried is cost sharing by consumers. Although cost sharing in this country is much higher than in some other countries, it is not rising by falling. The proportion of total costs that are paid out of pocket by the consumer has fallen from 46 percent in 1965 to 21 percent in 1989.

A number of health insurance experiments have been made to see what would be the impact if we could increase cost sharing by the consumer, and evidently it takes a big change in cost sharing to produce a relatively small decrease in total spending.

If we had been able to raise the cost sharing rate in 1989 from the 21 percent, which I mentioned before, to 31 percent—in other words, boost it by 10 percentage points—spending would have decreased by only 1 or 2 percentage points, or by somewhere between $6 billion and $12 billion out of a total bill of close to $600 billion. So, a big change there would produce a relatively small bang at the other end.

It is also important to realize that had we gone this route, it would probably have had a much greater impact on low-income Americans than on upper-income Americans, in terms of the amount of health services consumed.

A second strategy to control costs is called "managed care." This policy involves third-party payers reviewing and intervening in the decisions concerning the provision of health services. This is done in an effort to reduce unnecessary or inappropriate health services, and studies have shown that a considerable quantity of such services is provided.

Managed care also may involve placing limitations on patients' choice of providers—in other words, limiting the number of providers they can turn to.

Studies of managed care have concluded that, despite its significant administrative costs, managed care has the potential to effect a one-time reduction in the level of health care spending. But it doesn't seem to have much of an impact on the rate of increase after that one-time reduction is achieved.

In a fragmented system of financing such as the one we have in the United States, the savings realized from managed care of one group may resurface as increased services or prices for other groups that are not within this managed care framework.

Price controls represent a third strategy for controlling spending, and we have imposed them several times, but the evidence suggests that they are not very effective. Across-the-board price controls stimulate the provision of more services. Selective controls create incentives for providers to substitute non-controlled services for controlled services. Controls that are established for one specific population group, such as Medicare recipients or Medicaid recipients, may result in higher prices being charged to other population groups such as those covered by employer-based plans.

Thus, unless price controls are combined with systematic monitoring and review of all providers to prevent the volume of services from rising, their potential to solve the problem of health care costs is really quite limited.

Increased competition among insurers and providers represents a fourth cost control strategy. It would seem that the degree of competitiveness should have soared in this country during the last two decades. The number of insuring organizations has grown substantially; more and more employees have been offered a choice of insurance plans, rather than a single option; and the number of physicians relative to the size of the population has grown by roughly 50 percent. Nevertheless, health care costs and spending have continued to grow at rapid rates.

Some researchers have concluded that in some places greater competition has not led to lower prices, but in fact has led to nonprice competition in the form of product differentiation, and that this maybe has even boosted prices and spending rather than lowered them.

However, I think to be fair, it must be said that the competitive strategy has not been put into place fully, and once in place it would probably take a long time before one would see the fruits of this strategy develop in their fullest form.

Regulation represents a fifth strategy for controlling spending, and this has been pursued in the United States through Federal health planning and certificate-of-need programs, and at the State level through all-payer rate-setting programs for hospitals.

Research on the effectiveness of certificate-of-need programs consistently found that they did not restrain hospital spending, and the Federal Government therefore dropped this requirement in 1986. Some advocates have said this was a premature step because the certificate-of-need requirements had been applied in an erratic or politically motivated manner in many areas. So I think the jury is still out on this one.

Studies of the all-payer rate-setting programs established in four States during the past two decades suggest that initially they can lower hospital costs anywhere from 2 to 13 percent, and that they do have the potential for cutting the rate of growth of hospital spending substantially below the rate that would occur otherwise.

Prospective spending limits are another regulatory mechanism for controlling health care costs. While other nations have relied on this mechanism through their global budgeting policies for hospitals or their expenditure caps for physician services, the first such move in this direction in the United States was the Medicare volume performance standards for physicians which were put into effect last year.

While such mechanisms can be effective if strictly applied, we have to keep in mind that they also could adversely affect the quality of or access to care.

Let me wrap this up by making four concluding points about the potential for controlling rising health care costs in the United States.

My first point is that the problems posed by controlling health care costs are much harder to deal with in this country than elsewhere, because we do not have a coordinated national health care policy or a national health system. As a result, our efforts to control costs tend to be piecemeal. Successful attempts to control health spending in one segment of the market or for one specific group too often are not reflected in overall health spending, because providers compensate for lower revenues from one segment of the market by increasing the prices for or the quantity of services provided to the other groups.

My second concluding observation is that, if we want to achieve greater control over health care spending, we will probably have to adopt policies that represent fundamental changes in our health care financing and delivery systems. Such policies might involve such fundamental changes as:

Eliminating first-dollar coverage under insurance policies and not allowing people to buy supplementary policies;

Applying uniform utilization monitoring and review to all physicians rather than to individual patients or to individual types of procedures;

Establishing uniform payment levels that encompass all payers;

Implementing health planning that establishes national and regional levels for capital and technology targets and that does not reimburse for services provided through unapproved purchases of capital equipment; and

Imposing effective national and regional budgets for overall spending, or expenditure targets for specific types of spending.

Each of these policies would be quite a radical departure from the system that we have currently.

My third conclusion is that such fundamental changes would necessarily involve difficult trade-offs, trade-offs that would entail sacrificing some of the desirable attributes of our current system. The changes would probably mean less spending on research and development, longer waiting times for the use of new technologies, and limitations on the substantial degree of choice that we as consumers now enjoy in this country.

My fourth and final point is that if we do not get a handle on costs, it will be extremely difficult to address the other major failure of our health care system, one which I have not said a word about. That failure, of course, is the large and growing number of people in the United States who do not have any health insurance.

That ends my statement. I will be glad to answer questions.

[The prepared statement of Dr. Reischauer appears in the appendix.]

The CHAIRMAN. Dr. Reischauer, that is informative and helpful.

Let me measure Medicare against the general availability and cost of health care, because there is a system for which we have to a degree tried to do something about controlling costs. We took steps to control costs with DRG's, then further with physician payment reforms, restrictions on referral to labs and other types of limitations. Yet, with all of that, CBO estimates that we are going to have a double-digit increase in costs, I believe, in Medicare in each of the next 5 years.

So, what I am trying to find out from you is how effective have these actions been in trying to control Medicare costs? Have we had a measure of success there or not? Are these approaches being replicated in the private sector? And, in turn, if we are really gaining in controlling Medicare cost growth, then has there just been a shift of those costs to the private sector?

Would you comment on that?

Dr. REISCHAUER. The answer to your question is that I think the measures that have been adopted during the 1980's with respect to Medicare have in fact held down Medicare spending to a significant degree.

We have tried to estimate this using two different methodologies and have come up with a rough figure that Medicare spending in 1990 is some 18 percent below where it would have been otherwise if the cost saving measures of the 1980's had not been adopted. So that is a very substantial reduction.

But as your question hinted, there is a strong possibility that much of the saving to the Federal Government and the Federal taxpayer in this area has really been shifted off onto employers, employees in the private sector of the economy, because spending in that segment of the market has in fact outpaced Medicare spending, particularly over the last half of the 1980's. This indicates that the forces at work in the Medicare segment of the marketplace have not been replicated elsewhere, possibly because providers have shifted costs onto the private sector.

The CHAIRMAN. Well, you talked about the multiplicity of payers and how one can perhaps, by the force of bargaining, get a better rate to take care of his company's employees, and then that in turn shifts additional costs over to others.

Then the debate becomes whether you go to a single payer. But that is fraught with a lot of problems, too, isn't it?

Dr. REISCHAUER. Well, there is a difference between a single-payer and an all-payer system. An all-payer system would be one in which all of the payers—whether they were individuals, Blue Cross type insurance companies, employers, private self-insured corporations, Medicare or Medicaid—paid a single rate. Then there wouldn't be this differential that you speak about, with healthier

groups being able to achieve lower rates than less healthy groups, and larger groups achieving lower rates from the provider than smaller groups.

The CHAIRMAN. One of the things we will be getting into here, of course, is the question of the availability of health insurance for small employers and the question of affordability of the insurance itself.

You look at situations today where you can have parents who have a child with a serious recurring illness, or another pre-existing condition; and yet, the person is offered a better job someplace else, but he is afraid to leave—he gets locked into position.

And then we run into other situations where insurance companies have a tendency to cherry pick: they will pick the company that has the younger employees with fewer health problems. Or you get one serious illness that escalates the costs enormously, and then you get an amazing escalation in the premium, or cancellation of the coverage entirely.

The multiplicity of problems here are just enormous. Hopefully these hearings can help us in that.

I have to put a 5-minute limitation on, as I had on myself, because of the intense interest in the subject. And we will get back and have another round of questioning, if you like, of each of these witnesses.

Senator Packwood, are there any questions that you might want to ask?

Senator PACKWOOD. I am curious. On page 17 of your statement, where you talk about expenditure levels, you say, "Or it can be done through caps on expenditures." I want to make sure I understand what you mean. If that is Medicare, does that simply mean the Government says, "We are only going to pay out $100 billion next year in Medicare, period. That is all we are going to pay. And we will adopt appropriate penalties or reductions in payments, or whatever is necessary throughout the fiscal year to get there." Is that roughly what you are talking about?

Dr. REISCHAUER. Yes it is, and there are a number of countries that in fact do that. It is conceivable that you might have a lag, so that if the expenditures in this year exceeded the limit that was placed on them, the reduction would be made in the following year

Senator PACKWOOD. Let me ask you, is that not unlike what Mr. Darman suggested a year or so ago?

Dr. REISCHAUER. Well, I believe it is not unlike what was enacted with respect to physicians by the Congress a little over a year ago. In that case rates of growth will be specified by the Secretary, and if the rate of growth is exceeded then there will be reductions in the rate of growth permitted in the following year or the 2 years following.

Senator PACKWOOD. That assumes the Congress doesn't intervene to prohibit the Secretary from doing that, as I recall.

Dr. REISCHAUER. I would hope not.

Senator PACKWOOD. Well, as I recall, that was a contentious issue when we did it, as to whether or not he could do it automatically, whether he would have to come to us prospectively to do it, or, rather, it would be like the fast-track agreement that is, unless we did something it would go into effect.

Dr. REISCHAUER. Right.

Senator PACKWOOD. And as I think Director Darman said—he was here with Dr. Sullivan—"Well, that is not good medicine," and I think Darman said, "I don't know if it is good medicine or not; it is good budgeting." It would indeed work to get the costs down without us understanding prospectively exactly what the side effects might be.

I had read your testimony before you came today. Go over it in a nutshell and give me what you think is politically acceptable to the public. I mean, you have been at this a long time, and you have heard us all argue this; but I absolutely swallowed hard when I saw your "20 percent by 1996." If we think costs have been growing fast now—we can't have 20 percent of our GNP going to health in 1996.

So what, in your judgment, is politically acceptable, passable, doable, to stop that from happening?

Dr. REISCHAUER. I am really not in a position to advise a Senator on what is politically acceptable.

Senator PACKWOOD. Actually, as a matter of fact, you are.

Dr. REISCHAUER. We are chosen for our jobs through a different mechanism, for our jobs, and I hope politics doesn't play a role in my judgment about this.

Senator PACKWOOD. Well, every now and then we can do something unpopular, and we can say, "Well, Reischauer said to do it." [Laughter.]

Dr. REISCHAUER. I don't think that will fly very far. [Laughter.]

Senator PACKWOOD. I don't think I have any other questions, Mr. Chairman.

Having watched this, I have come to this conclusion, after 16 years in this committee: There is a rhythm to the tax code, that once you get on to it you can understand it—you may not agree with the philosophy but you can understand it—but there is no rhythm to the way we reimburse medical costs or handle the problems of medical insurance. There is simply no pattern.

A time comes when we think rural hospitals are not reimbursed enough, so we increase them. And then middle sized hospitals say, "Well, we are not Cook County, and we are not a county with three thousand people; we are in between," and we give them something different. Or we try to bring in different health professionals for Medicare reimbursement and we leave out some others, and then the others who are left out complain, and eventually we include them.

I am not sure I know the answer, except I do know this: there must be some way to cover people who are now not covered. There has to be; they cannot afford it. And there has got to be some way to restrain costs.

I hope before we are done, Mr. Chairman, we figure out how to do both.

Dr. REISCHAUER. Can I just make an observation on the preceding question, dealing with the political acceptability of change in this country? This bears on the dilemma that faces you, because I think the public opinion polls show some rather conflicting pieces of information.

A recent poll that was done across half a dozen countries by the Harvard Community Health Plan seemed to indicate that Americans have a very high degree of satisfaction with the care they are receiving. They were asked questions such as, "Do you like the hospital and the treatment you received? Do you like the doctor and the treatment you received?" And so on.

On the one hand, this poll showed a degree of satisfaction that is particularly strong among those who have health insurance. Americans probably don't perceive how much they are paying for the health care insurance they are buying through reduced wages.

On the other hand, other polls show a very high degree of dissatisfaction with the American system. This seems to focus on the payment mechanism, the insurance policy, the complexities of the sea of paper one is involved in, the claims that have to be filed, and the delays, and the uncertainty with respect to whether one is going to be reimbursed, and how much.

So, on the one hand you have a degree of satisfaction, reflecting the fact that we do have a system which provides tremendous choice to the consumer, the highest level of technology available anywhere in the world, access for those with insurance that is really unequalled; and yet, on the other hand, dissatisfaction with this Byzantine system of financing.

It is going to be very difficult, I think, to change one without sacrificing the other.

The CHAIRMAN. Gentlemen, I am going to violate the "early arrival rule" because of the responsibilities of the Majority Leader and call on him, and if any of you fellows on this side want to object to that, why, go right ahead. [Laughter.]

Senator MITCHELL. Mr. Chairman, thank you very much, and I thank my colleagues for their courtesy and patience.

Mr. Reischauer, I would like to follow up on Senator Packwood's line of questioning, because I think it is the central problem that we confront. How can we, on the one hand, broaden coverage by providing insurance for those who don't have it, which will inevitably produce greater demand, and at the same time control costs so that the system doesn't explode in the manner you have suggested it might?

You identified five areas, and you listed them 1 through 5. May I take it that that was not in order of priority but merely a convenient method of listing for you?

Dr. REISCHAUER. That is correct.

Senator MITCHELL. The first one was increased cost sharing.

Dr. REISCHAUER. Yes. Right. I started with what the economist usually does, which is "vary prices."

Senator MITCHELL. Let me phrase it a little bit differently from the way Senator Packwood did: Is it your conclusion, or may I take it to be your conclusion, that some combination of these factors is the only practically feasible way to control costs in the current system?

Dr. REISCHAUER. I think several of these policies imply changing the current system. The regulatory approach that I spoke of really would involve some fundamental changes in our system. So would managed care.

What we have tried to do over the last several decades is to impose these strategies in a piecemeal way without changing our system, and the bottom line seems to be that they haven't worked, or they haven't worked to the satisfaction of the needs of our society and of our public sector.

Senator MITCHELL. Well, let me go back then and see if I understand your testimony. Are you merely listing the things that have been tried? Or are you suggesting a course of action adjusting it forward?

Dr. REISCHAUER. I am not suggesting a course of action, no. I think that, once again, is your job.

Senator MITCHELL. Then let me invite you to do that.

We have to devise some method of controlling costs. It is essential both to be politically acceptable and practically feasible in the current system. However one frames the question, that is an essential element, and what we need is the best advise we can get on how we can effectively control costs.

You may not wish to do this now, but may I invite you to go back over the areas which you have suggested as possible approaches and give us your best recommendation on what we can do in that regard?

I think that is what we need, because I don't think we can pass it, politically, if it doesn't have effective cost containment. And even if we could pass it, we would be back at it in a year or two, struggling with that element of it—probably sooner. So I think that is essential to our consideration.

My own view is that it is going to have to be some combination of these factors: increased cost share, managed care, increased competition, some varying form of regulation. "Regulation," of course, is a generic term which can embrace a wide variety of approaches, some of which we have tried and some of which we haven't but that we could approach.

But I would like very much if you could give us that in the form of a supplement to your testimony.

Dr. REISCHAUER. All right.

The "it" you were referring to is policies to expand coverage to those who do not have coverage now?

Senator MITCHELL. No, I am referring to——

Dr. REISCHAUER. You said, "We won't be able to do 'it' unless we get some control over costs."

Senator MITCHELL. That is correct.

Dr. REISCHAUER. Which is, if the "it"——

Senator MITCHELL. Well, it is twofold. That is a step to a larger objective. It seems to me the "it" is good health care for all Americans.

Dr. REISCHAUER. All right.

Senator MITCHELL. That is what our objective is. And what we see now is a twofold problem which is in direct conflict: on the one hand an area of unmet need, and on the other hand very rapidly rising costs. How can we meet the area of unmet need without aggravating the already excessive rate of increase in costs? I think that is the dilemma that we face and to which we look to you and the other witnesses for advice and counsel.

Dr. REISCHAUER. All right.

[The information follows:]

Our review of the available evidence on the effectiveness of various strategies for controlling health care costs suggests:

• If the goal is to control the level and rate of increase of overall health spending in the nation, then policies that encompass the entire health care system—rather than segments of it—would be necessary. Partial controls on spending for health are more likely to shift costs to some less controlled segment of the market than to reduce costs.

• No single policy to control health care costs, if adopted in isolation, is likely to be effective. Increases in per capita spending for health can come from higher prices, a larger volume (either number or quality) of services per person, or less efficiency in the provision of services. Consequently, a coordinated set of policies would be required—policies designed to control both price and volume, while assuring that quality would not be compromised.

One policy combination that could increase the ability to control costs, while minimizing the direct impact on patients, would include:

• Uniform payment rates for all providers in a given locality;

• Uniform utilization review procedures applied to all providers in the locality; and

• Planning for and controls on medical facilities and capital-intensive technologies in the locality.

If applied by only one payer in our multipayer system, this combination of measures might be successful in reducing that payer's costs for its insured population. But the providers affected would probably recover some or all of the lost revenue by increasing prices for other patients, or by increasing the volume of services provided to them. As a result, national spending for health might not be reduced by much. Further, each individual insurer's ability to control costs is very limited in a multipayer system because strict controls by any one insurer will threaten access for that payer's insured population if providers come to prefer other groups with less restrictive payers.

If only prices were controlled (even if by all payers), it is likely that providers would circumvent the effects by increasing the volume of services provided or reducing quality of care. If only utilization review procedures were put in place to control volume and assure quality, providers could circumvent the effects on revenues by raising the fees they charge.

Health planning could ensure that adequate, but not excessive, capacity existed to provide necessary services. Without planning, excess capacity is likely to develop. In this case, if controls on volume were not entirely effective, the existence of excess capacity would lead to greater use of the services provided by the facilities than was necessary for appropriate care.

The level of effectiveness of these strategies—and of other approaches such as increased consumer cost sharing and expenditure limits—would depend upon the stringency of the controls on prices, utilization, and technology that would be put in place. The impact of these strategies on access to new technologies, waiting times for services, and consumers' freedom of choice of providers, insurance coverage, and treatments also would vary with the stringency of the application of cost control policies.

The CHAIRMAN. Thank you.

I must say, Dr. Reischauer, that I certainly agree with the Majority Leader. If you can give us a practical, politically possible solution to this—they don't know how to spell "Reischauer" in Texas now, but they will know how. [Laughter.]

Dr. REISCHAUER. Mr. Chairman, it is not that I have a plan in my pocket that I am withholding from the committee.

The CHAIRMAN. All right.

We have quite a number of very able distinguished witnesses and a tough timetable here, so let us move on.

Senator Rockefeller?

Senator ROCKEFELLER. Mr. Chairman, I want to try to get in just two questions to Bob.

Earlier this year you put out a study which revealed something which is really stunning to me. While our health spending on a per capita basis grew by about 176 percent between 1965 and 1987, when you looked at those countries that had a national health insurance system—for example, Canada, Germany, or Japan—that their so-called "per capita" rates also rose. In fact, some rose at a higher level; 172 percent in the case of Canada, 339 percent in the case of Japan. Only West Germany had a slightly lower rate.

So my question is, what does this suggest to you? In the five proposals that you have at the end of your testimony, for example, you list "first-dollar coverage." Well, you know, only 5 percent of coverage is now first-dollar coverage. It is not much.

Are you saying that if you do all of your proposals for cost containment, or whatever it is that you are going to provide to the Chairman, that you only get a one-time large reduction in health spending? Or, are you saying if we did the five proposals on page 19, that we would at least have a shot at reducing the rate of growth? And, what do those earlier figures suggest to you?

Dr. REISCHAUER. If we went to global budgeting for hospitals and caps for physicians, and these encompassed all providers, then, clearly, he rate of growth would be largely determined by how rapidly these caps were raised, how rapidly the budgets were expanded, and that would be a political decision as much as a marketplace or a medical decision, which is where it is now. So, the rate of growth of spending could be lower if the political system could take the heat.

Let me just go back and talk a bit about the numbers you mentioned, which came from, as you said, a report we issued last December, which involved 1965 to 1987.

I went back and calculated what had happened from just 1980 to 1987, because you are right, many other countries have had very rapid rates of growth over this 20-year period. But let us look at the more recent period, because changes have taken place in the health care systems in all of these countries as well as in our own.

From 1980 to 1987, which is the last year for which we have comparable types of data, the United States' real per capita health care expenditures rose by 33 percent. That wasn't the highest; Canada was the highest. Canada's rate of growth was 38 percent over that period. Japan was not far behind at 31, a couple of percentage points below the United States.

However, Germany and the United Kingdom were considerably below these other countries. In Germany per capita health care expenditures increased only 13 percent, and in the United Kingdom, 22 percent. So I am not sure there is an obvious conclusion arising from this. One conclusion way be that you can have a relatively tightly managed health care system and growth can be either high or low.

Senator ROCKEFELLER. It depends, even if you have a single payer system, on how you operate that system. I guess that is the point of it.

Dr. REISCHAUER. Right. And the Canadians have shown that you may have rapid growth, which of course is undesirable.

Senator ROCKEFELLER. Yes.

Dr. REISCHAUER. And the Germans have shown the opposite.

Senator ROCKEFELLER. One other question, which is related somewhat to that, is the managed care question. You have suggested that it really doesn't appear to affect the rate of increase that substantially.

First, does that apply to all types of managed care, or only for HMO's? You know, some people are moving closer to loosely-defined provider networks——

Dr. REISCHAUER. No, I think the conclusion applies only to the more traditional HMO's. Those that have the staffs themselves, where the doctors work only for the HMO's, which have a relationship with the hospital, are much better at controlling costs and holding down the rate of increase.

Senator ROCKEFELLER. Gotcha. One of the fellows who is going to testify after you is the President of Southern California Edison, Michel Peevey. His company is using managed care and, I believe, he will testify that they are experiencing significant lowered health care costs, real cost containment, as a result of managed care.

So the philosophical approach to managed care on your part—I mean, are you a believer or are you a non-believer? You are a skeptic, I take it, in spite of some examples of success?

Dr. REISCHAUER. You know, it is difficult to generalize as to what managed care applied to the whole country would achieve on the basis of evidence from managed care applied to a minority of Americans in very different ways in a health care system the balance of which is largely unregulated.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Durenberger?

Senator DURENBERGER. Mr. Chairman, thank you, and thank you for the series of questions and comments that you made about the need for small employer health insurance. You certainly have a background and an insight into the subject, and a sensitivity to it. And Bob, thank you for your responses.

I would also recommend that anybody with the time read the Secretary of HHS's speech down at Rice University, 2 weeks ago, on March 26. He addresses the same issue very lucidly.

Bob, my question is regarding the function of cost sharing. The heart of this problem is that if we don't control cost escalation, we don't get to provide access. In the beginning of your statement, you said that a major contributor to the rapid increase in costs and the high costs involved is the utilization of insurance in this country; that leads to over-consumption.

But on page 11 of your statement, and I think in your oral statement too, you mention the fact that in the United States about 21 percent of the costs in 1989 were out-of-pocket, whereas in West Germany it is 7 percent and in the UK it is 3 percent.

Dr. REISCHAUER. Yes.

Senator DURENBERGER. So I guess my question is——

Dr. REISCHAUER. What is happening here?

Senator DURENBERGER. Yes. What do we get by more cost sharing?

Dr. REISCHAUER. The only country that comes close to us in cost sharing, of the industrialized nations that I have looked at, is France. In all the others, as you have pointed out, cost sharing is

minimal compared to what it is in the United States. Now, it might be relatively high for specific categories of service; for instance, I don't think prescription drugs are covered in Germany or Canada under the regular national systems. In Canada, I believe, people buy supplemental policies for that.

We can't look at this dimension-by-dimension and say, "Why, look: cost sharing is much higher in the United States than it is elsewhere, yet these countries maybe have done a better job controlling costs," because they have done it through other mechanisms.

In the British system, clearly, costs are controlled by regulating your access, your ability to choose a physician, and in some other countries by your limited ability to have your physician treat you in a hospital setting—rather than being treated by an individual who is an employee of the hospital. But in all of these systems, really, the teeth consist of some form of expenditure caps or global budgeting, not cost sharing. The fact that they have much lower cost sharing than the United States means that the other strategies they use have to be tougher.

Senator DURENBERGER. So, one of our problems is looking at these sorts of things globally—I mean, in the larger, in the percentage context.

Dr. REISCHAUER. Right.

Senator DURENBERGER. If we were to look at cost sharing in the specific service context, we might come to a different conclusion.

Dr. REISCHAUER. Right.

Senator DURENBERGER. Like you say, "Eliminate first-dollar coverage." Well, that simply means that no cost involvement by a consumer of a product makes it a free product; it means they play no role at all in determining quality, cost constraints, or any of those issues.

Now, cost sharing, I take it, has an appropriate use if you match it up against the service. And if we ever got to the point where we could say, "These services are emergency services; these services are necessary services; these services are important but not necessary; these are optional," or something like that, and then match the consumer's participation, would that not be an appropriate use of cost sharing?

Dr. REISCHAUER. Yes, it would, and to a certain extent we do that already. Many plans will pay 100 percent of hospitalization but only 80 percent of physicians' visits. Some plans provide a lower reimbursement percentage for psychiatric care than for other types of care; or reimburse elective surgery at a lower percentage than other surgery.

That is clearly the direction one would want to go if one were to put a heavier reliance on cost sharing; one wouldn't want to put it on emergency types of care.

Senator DURENBERGER. In honor of John Heinz I am going to ask you a question and not ask you to answer it here today, but to ask you to answer it in the follow-up, if you would.

We all respect your judgment greatly. You engaged in a conversation with Jay about all-payer systems, and so forth, which is very appropriate, and one of your recommendations is "uniform pay-

ment levels that encompass all payers, eliminate balance billing, utilization of budgets," and that sort of thing.

It seems that these kinds of controls, if you don't put them in place, you said, causes cost shifting from a controlled system to a non-controlled system. By the same token, I would suggest that it eliminates the incentives to find better ways to do things: more efficient ways to practice medicine, better ways to use—in other words, by paying everybody the same thing for the same basic service, you take away the incentive from a specific provider to find a better way to do this thing, so that more people will come to that provider even at that particular price.

The other thing you do in this system: as the efficient person finds a better way to do things, all the prices get driven down to that new level.

Dr. REISCHAUER. And that forces efficiencies on the inefficient. But remember, there are other ways——

Senator DURENBERGER. Well, I really wanted to just get the question on the table.

Dr. REISCHAUER. Okay.

[Dr. Reischauer's answer follows:]

Price controls—paying less per unit of service—would not necessarily result in lower expenditures overall, because the number of services provided could Increase, the services provided could shift toward a more costly mix, and providers could change the way that they bill for services (e.g. "unbundling" a package of services into individual services).

There are examples from the Medicare program of these types of responses. During the 1984–1986 freeze on physicians' fees under Medicare, real spending per Medicare enrollee for physicians' services increased 9 percent between 1984 and 1985 and 8 percent between 1985 and 1986.

Beginning in 1983, Medicare also instituted a system of controlled prices for hospital services, combined with review of hospital admissions. Over the first 5 years of the new system, admissions of Medicare enrollees to hospitals fell 12 percent and the average length of stay in the hospital fell 10 percent. The Medicare payment levels over this period also rose at less than the rate of growth in costs. Despite the lower utilization and the constraints on prices, real spending per enrollee for hospital services continued to increase at a rate of about 1.3 percent a year.

There is another reason why price controls are not effective in our health care system. Under our multiple payer approach to financing health care, controls are generally put in place only for subgroups of the population (e.g. Medicare). When this occurs, providers appear to be able to change the way they practice and the prices they charge to other payers in order to offset the revenue losses that might result from the controls on prices (or utilization) imposed by one payer. Thus, price controls may result in lower spending for the subgroup involved but total revenues to providers from all payers may not be diminished.

Price controls also may have an effect on the efficiency of providers of health services. Unlike the incentives for inefficiency provided by the previous cost-reimbursement system, under the Medicare hospital prospective payment system, for example, hospitals have incentives to provide care to Medicare beneficiaries using the least costly combinations of resources and to discharge patients to appropriate lower levels of care as soon as possible.

The problem of establishing the price that creates incentives of efficiency without deterioration in the quality of care is a difficult one. If the controlled prices were set at a level that was higher than the cost of efficient production, then providers would have less incentive to reduce inefficiencies in their provision of care. If the controlled prices were set at a level below the cost of efficient production, there could be negative consequences. Some providers might reduce the quality of care they were providing below an acceptable level. Other providers might go out of business, leaving some patients without adequate access to care.

The CHAIRMAN. Gentlemen, we have to move along.

Senator Breaux?

Senator BREAUX. Thank you, Mr. Chairman, and thank you, Doctor, for your very extensive work in this area.

In my own State of Louisiana the statistics are really frightening: we have the third highest percentage of uninsured folks under the age of 65, which is 25 percent of the total population of my State, and we have the seventh highest in terms of absolute numbers, and it is relatively a very small State. It is a very big problem in Louisiana, just with the insurance.

Let me ask a question about insurance reform. What is the role in this possible solution that we are talking about with regard to insurance reform? If we used the community-ratings type of process, would that be helpful? Have you thought about that idea?

Dr. REISCHAUER. Well, community ratings would even out the premiums that are charged to small firms relative to large firms, and to firms with relatively unhealthy work forces relative to those that are healthier. They would reinstitute the cross-subsidization that was a major element of U.S. employer-provided health insurance back in the 1940's and 1950's and 1960's and then began to fade as we developed more competition.

The interesting thing here, of course, is that competition can exacerbate certain problems. When competition developed between standard insurance and HMO's, then it became in the interest of the private insurance companies to begin to offer experience-rated premiums and to do underwriting; whereas, it wasn't before. I think community ratings would make the system more equitable and make some small difference in the situation in Louisiana. But I don't think they would make a significant difference.

The major problem here, and a problem which I think exists in many States in America, is that health insurance is terribly expensive. Relative to the wages of low-skilled individuals it becomes prohibitively expensive from the standpoint of the employer.

The employer, when he is hiring somebody, is interested not in the cash wages he pays but in the total compensation costs, and those total compensation costs consist of wages plus fringe benefits. A growing component of fringe benefits and total compensation is health insurance premiums.

Senator BREAUX. What about the administrative costs in the United States for our health delivery system in comparison to what other countries are paying with their programs?

It seems to me, because of the numerous different ways of handling administrative costs—the duplication, the overlapping—that we are spending a lot more on administrative costs as far as the actual services that are being delivered to the patients.

Dr. REISCHAUER. That is a correct conclusion. I think something like 4.6 percent of our health spending is in the form of administrative costs for the insurance policies, in both the government and the private sector, and I think they are roughly 2.5 percent of total spending in the Canadian system and some of the European systems. Of course they include the costs associated with marketing, with assuring that the insurance company receives a profit, and so on.

Our Medicare and Medicaid systems operate with roughly the same administrative costs relative to total benefit spending as in the Canadian and European systems.

In addition, of course, there are very significant administrative costs in physicians' offices, hospitals, nursing homes, and other providers, just in keeping track of the paperwork, filing the claims, and figuring out exactly what reimbursement one is going to get from the vast variety of insurance companies. I think these administrative costs amount to close to 18 percent of the total health care bill.

The costs could be substantially reduced if we went to another system. But once again, there are trade-offs involved. We would be giving up some of the positive attributes of our current system.

Senator BREAUX. Thank you, Bob.

The CHAIRMAN. Thank you.

Senator Daschle?

OPENING STATEMENT OF HON. TOM DASCHLE, A U.S. SENATOR FROM SOUTH DAKOTA

Senator DASCHLE. Dr. Reischauer, I was interested in your latest figure on administrative costs, because I have always used the figure that about $1 in $5 is spent on administrative costs in our system.

Just for the record, I think it would be helpful if we could just have a more elaborate explanation of "administrative costs." I think that is one of the key questions as we look to alternatives and cost control. My view is that administrative costs to a large extent are driving the proliferation of costs, and I would like to address that.

The other point I would make is, when we talked about comparative per-capita costs, there is one glaring omission that I think for the record is very important, and that is, the United States—correct me if I am wrong—is the only industrialized country that does not now provide universal access. Is that not correct?

Dr. REISCHAUER. Correct.

Senator DASCHLE. So, by failing to provide universal access, we are really talking apples and oranges here, are we not? I mean, it is hard to say, "Well, the United States is controlling its costs"—you use the figure 33 percent, next to Germany, which is 13 percent, when there is a phenomenal difference in the quality of care provided in the two systems, if one considers universal access.

Dr. REISCHAUER. Well, universal access would change the level of spending, not necessarily the rate of increase of spending. With that number of 33 percent, I was talking about the rate of increase of spending. It is conceivable that the rate of increase would be the same. In fact, if we had universal access, it might even be lower, because you would be bringing on a group of people who, with cost sharing at what it is in this country and the rate of increase of prices, would not expand their medical use as much as others.

Something like 13.4 or 13.6 percent of our population does not have coverage. That doesn't necessarily mean that if they were provided insurance, costs would rise or total expenditures would rise by 13.4 percent, because many of those people, as a number of your colleagues have pointed out, are receiving some care—although, very often it turns out to be in the emergency rooms of hospitals

and is unreimbursed. But it is still counted in total health care expenditures.

Senator DASCHLE. Well, you are certainly the budget expert here, and I wouldn't want to challenge that, but it would seem to me that if this country tomorrow were to provide universal access, there would be a proliferation of cost on a per capita or any other basis, and we would have to take that into account.

I think I know what you are saying, that once that is established, on a relative basis per-capita increases are such; but I think it is important that we note universal access is a major flaw in this system that we obviously are trying to address in various ways.

Are there not two concepts to cost control, or maybe three, one being regulatory—that is, cost sharing, managed care, price controls, and what you define as "regulation." Those would all be regulatory concepts.

The second, it seems to me, is a global budget. You have a certain amount of money that is going to be the determinant of how much a country spends.

As we look at all of our industrial competitors, is there any competitor today who does not use the globalized budget concept?

Dr. REISCHAUER. Well, there is "global budgeting" and then there is "global budgeting." I think the situation in Great Britain conforms to a strict definition of "global budgeting"—the government determines how much is going to be allocated to the national health system each year.

In the Canadian system, the Federal government provides a certain amount that is determined by a formula; the provinces can then add in varying amounts, and over half of the population goes out and buys a supplementary policy. So, you have quite a variation.

But in general, the use of expenditure caps or global budgeting is relied on in virtually all of the other industrialized countries.

Just one other observation: You mentioned administrative costs and your interest in those. You are right, they have been growing faster than other health care expenditures over the last decade. We have some comparative information on administrative costs, both in the United States and in several other countries, broken down by providers and insurance companies, and I will submit it for the record.

Senator DASCHLE. That would be very helpful.

[The information follows:]

The proportions of health spending accounted for by the administrative costs of insurance companies and of health care providers are higher in the United States than in other industrialized countries (see Table A). In 1987, the share of national health expenditures spent on program administration and insurance overhead was 4.6 percent in the United States, 2.5 percent in Canada, and 2.6 percent in Great Britain. The percentage is higher in the United States because overhead in the private insurance sector comprises 10.8 percent of private-sector health spending. Administrative costs for Medicare and Medicaid, as a share of these programs' benefits, are comparable to other countries' administrative costs as a share of spending.

The United States also spends more than other countries on hospital and nursing home administration and physicians' overhead (see Table B). In 1987 the United States spent 17.6 percent of national health expenditures on providers' administration, compared with 6.4 percent in Canada and 9.0 percent in Great Britain. The fragmented health care system in the United States results in providers' incurring costs to keep track of many different insurance plans and to market their services.

Table A.—COSTS OF PROGRAM ADMINISTRATION AND OVERHEAD FOR PRIVATE HEALTH INSURANCE

	Overhead cost (In billions of 1987 dollars)	Share of national health expenditures (In percent)	Share of program spending (In percent)
United States	22.4	4.6	4.6
Private insurance	16.9	3.5	10.8
Medicare	1.7	0.3	2.0
Medicaid	2.5	0.5	4.9
Canada	1.2	2.5	2.5
Great Britain	0.6	2.6	2.6

SOURCES: National Health Expenditure Accounts, Health Care Financing Administration; "Health Care Expenditure and Other Data: An International Compendium from the Organization for Economic Cooperation and Development," OECD Secretariat, *Health Care Financing Review,* 1989 Annual Supplement; "Cost Without Benefit: Administrative Waste in U.S. Health Care," *New England Journal of Medicine,* February 13, 1986.

Table B.—PROVIDERS' ADMINISTRATIVE COSTS

[Costs in billions of 1987 dollars; shares in percents]

	Hospitals (Share of national health)		Physicians (Share of national health)		Nursing Homes (Share of national health)		Total (Share of national health)	
	Cost	Expenditures	Cost	Expenditures	Cost	Expenditures	Cost	Expenditures
United States	37.1	7.6	43.0	8.8	5.9	1.2	86.0	17.6
Canada	2.1	4.3	0.9	1.8	0.1	0.3	3.1	6.4
Great Britain	1.3	5.2	0.8	3.1	0.2	0.7	2.3	9.0

SOURCES: National Health Expenditure Accounts, Health Care Financing Administration; "Health Care Expenditure and Other Data: An International Compendium from the Organization for Economic Cooperation and Development," OECD Secretariat, *Health Care Financing Review,* 1989 Annual Supplement; "Cost Without Benefit: Administrative Waste in U.S. Health Care," *New England Journal of Medicine,* February 13, 1986.

Senator DASCHLE. Competition is the third area, and I am not sure one could say that that is—it is, arguably, a cost containment measure. But those are the three systems.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Pryor?

OPENING STATEMENT OF HON. DAVID PRYOR, A U.S. SENATOR FROM ARKANSAS

Senator PRYOR. Mr. Chairman, I promise you I will not take my 5 minutes. This is going to be very brief.

I have just been looking out in the audience today, Bob, and my guess is that in this audience today probably 90 to 95 percent of the people in this audience have some form or type of health insurance. That is just a guess; I will not ask for people to raise their hands.

Second, I have heard a figure, and I didn't see it in the CBO study—by the way, which is very good, and I applaud you for it—a figure of 15 percent of all insurance premiums by those who have insurance are to cover the cost of uncompensated care. Is that a correct figure? Have you heard that figure?

Dr. REISCHAUER. We don't have a number, but that strikes me as being very high. We will look into that and try to find it for you.

Senator PRYOR. Thank you. I would appreciate that, because that is going to be a very key factor, I think, in the deliberations in the coming weeks and months on this debate on health care.

[The information follows:]

The effect of uncompensated care on the level of private health insurance premiums depends on the ability of health care providers to shift uncompensated costs to private payers through price increases and on the magnitude of uncompensated care relative to total private insurance spending for health care. The estimate that 15 percent to 17 percent of private health insurance premiums are due to uncompensated care appears to be higher than can be supported by the limited evidence available.

Although data are not available to estimate the magnitude of total uncompensated care for all services, the hospital sector can provide information on the potential effects of uncompensated care on private insurance. In 1989, U.S. hospitals incurred $8.9 billion in uncompensated care costs (charity care and bad debt) that were not offset by subsidies from State or local governments. Assuming that all of these costs were borne by private insurance, then about 11 percent of payments by private insurance for hospital services would have been due to uncompensated hospital care.

The actual proportion of expenditures by private insurance for hospital services that is due to uncompensated care is probably less than 11 percent, for two reasons. First, some costs associated with uncompensated care are probably covered by other sources of revenue, such as private philanthropy, other types of nonpatient revenue, and consumers' out-of-pocket expenditures. Also, the additional payments Medicare provides to hospitals that serve a high proportion of low-income patients, through the "disproportionate share" adjustment, may in part cover some of the costs of uncompensated care. Second, evidence indicates that at least some hospitals are limited in the extent to which they can shift costs to other payers. In 1988, for example, approximately 35 percent of hospitals reported overall losses on their operations. Clearly, these hospitals were not shifting all uncovered costs to private payers, or such losses would not have occurred.

While some uncompensated care costs are incurred by providers other than hospitals, it is generally thought that hospitals provide a significantly higher share of uncompensated care, on average, than other providers. Therefore, the total effect of all uncompensated care on total spending by private health insurance is probably lower than the estimate of the potential effect of uncompensated care on private insurance spending for hospital services.

Senator PRYOR. The second question that I have is the tremendous increase in prescription drugs. The pharmaceutical manufacturers today are raising the cost of prescription drugs at a rate three times—three times—the cost of inflation. My question to you is: If we go to an all-payers plan, that you have discussed and perhaps that you envision or propose, would an all-payers plan have any mechanism embodied in it that would have a controlling factor on the cost of prescription drugs?

Dr. REISCHAUER. I would think you could. You could have a price list that would then be renegotiated or changed every year.

Senator PRYOR. A national formula, or something of that nature?

Dr. REISCHAUER. Right, something of that nature.

Senator PRYOR. Well, Mr. Chairman, we will go into this later with some other witnesses. I do thank you, and I yield back the balance of my time.

Thank you, Bob.

[The prepared statement of Senator Pryor appears in the appendix.]

The CHAIRMAN. Thank you very much.

Senator Danforth?

OPENING STATEMENT OF HON. JOHN C. DANFORTH, A U.S. SENATOR FROM MISSOURI

Senator DANFORTH. Dr. Reischauer, if we go to universal coverage, covering 30-plus million additional people, obviously the cost is going to balloon very substantially unless we figure out some way

to spend less money per capita on those we are covering. That is reasonable, isn't it?

Dr. REISCHAUER. Yes.

Senator DANFORTH. So what we have to do is to figure out some politically acceptable way of spending less money per person.

It seems to me that the political trade-off is that we say we are going to extend health care coverage to everybody, but we are going to have some mechanism by which we can spend less per capita. Isn't that necessarily what we have to do?

Dr. REISCHAUER. If you don't want a large increase in total health expenditures from the inclusion of those without coverage, you are going to have to take a step like that.

Senator DANFORTH. Right. And most particularly, somebody, whether it is Congress or somebody else, is going to have to decide, I take it, that very high cost procedures that are now being paid for by the government aren't going to be paid for anymore.

Dr. REISCHAUER. That could be. It is not necessary. There is also the number of these procedures that we do. For certain procedures, we do many more in this country than are done in other countries. Also, the number of procedures done per thousand of the population varies tremendously across the country, and there is some evidence that a substantial minority of these procedures are medically unnecessary. If we could get a better handle on that, it would be a way of saving money, without necessarily saying that we will not pay at all for procedure X or procedure Z.

Senator DANFORTH. All right. Somebody is going to have to say no to somebody.

Dr. REISCHAUER. Yes.

Senator DANFORTH. Either saying no, across the board, or for certain types of procedures you would have some way to limit the people for whom the procedures are being performed.

Isn't global budgeting—I mean, I know that you are not here to give us political advice, but Senator Packwood asked you.

It would seem to me that the political solutions are two: first that we do go to universal care; in other words, we say that there is going to be some sugar-coating for this very bitter pill; and the second thing that we do is to use global budgeting, and say, in effect, "Look, here is the limit on what government is going to spend." And somebody has to figure out how to spend that money most cost effectively.

Dr. REISCHAUER. The difficulty, of course, is that government isn't the only spender here; in fact, it is a minority spender.

Senator DANFORTH. But it could be.

Dr. REISCHAUER. It could be, and that would involve a very fundamental change in our health care system.

Senator DANFORTH. That would be the Canadian system.

It would seem, also, that one thing we should consider is how to provide preventive care, so that the high-priced cures are less necessary than they are today.

I was told at St. Louis Children's Hospital that the leading cause of admissions is measles. There is no reason why measles should be the cause, as I understand it, of anybody being admitted to the hospital. But people aren't being immunized now. That would be one

area that we should explore, wouldn't it? Immunization and preventive care?

Dr. REISCHAUER. Well, I think you are suggesting that there are certain areas where we can spend money to save more money in the long run.

Senator DANFORTH. Right.

Dr. REISCHAUER. And more of an emphasis on preventive care, and well-baby care, that type of thing, could possibly do that.

Senator DANFORTH. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Let me say I know that each of us has more questions to ask Dr. Reischauer, but we are really running behind, and we have some very able witnesses coming.

So, Dr. Reischauer, we are very pleased to have you. Thank you.

Dr. REISCHAUER. And we will be glad to answer any questions that members of the committee would like to submit for the record.

The CHAIRMAN. Good. Thank you very much.

The CHAIRMAN. I would like to call now Mr. Lane Kirkland, president of the AFL-CIO, Washington, DC.

Mr. Kirkland, we are pleased to have you, and we are looking forward to your testimony. You have appeared before this committee many times, and we have always found it productive and interesting.

STATEMENT OF LANE KIRKLAND, PRESIDENT, AFL-CIO, WASHINGTON, DC, ACCOMPANIED BY ROBERT McGLOTTEN, LEGISLATIVE DIRECTOR, AND KAREN IGNAGNI, DIRECTOR, DEPARTMENT OF EMPLOYEE BENEFITS

Mr. KIRKLAND. Thank you very much, Mr. Chairman.

I have with me Robert McGlotten, director of our department of legislation, and Karen Ignagni, director of our social insurance department. She is the person who really knows what I am talking about. [Laughter.]

Mr. Chairman and members of the committee, thank you for the opportunity to present the AFL-CIO's views on this most critical issue to working people and their families.

As grave as it is, America's health care crisis appears to be at the stage where a genuine resolution is at hand. You and your colleagues, Mr. Chairman, now have the golden opportunity to be the Congress that finally enacts national health care reform.

This is, for the most part, due to a kind of harmonic convergence of the various interests and constituencies that have for years been at each other's throats over this issue. Organized labor, organized medicine, and many in the business community are at long last forming a consensus around the notion that the current health care system just does not work for the average American. We find ourselves in virtual agreement over the three basic goals of lowering the cost, expanding access, and improving the quality of our health care system.

The remaining challenge is to nail down the specifics, not a simple task but achievable, nonetheless, especially given the new climate of urgency, cooperation, and compromise.

It is, perhaps, a universal sense of complete frustration with the current health care system that is bringing us together in the search for a solution to this problem.

For our part, the labor movement is now convinced that the answer does not lie with the collective bargaining system; we need a national solution, and we are prepared to negotiate on the particulars with all who share our basic goals.

Meanwhile, doctors and other providers see a bleak future for their professions if the crisis lingers. Our Nation's business community is coming around to the realization that social dollarnism is no way to dispense health care to a work force whose productivity will determine how well American industries fare in the world economic competition of the 1990's and beyond.

Most importantly, all three sides are concerned about the widespread and abject suffering that this crisis has brought to working Americans and their families.

Last Fall, during the AFL–CIO's eighth regional hearings on health care, we heard from the victims of this crisis. They were not drawn from the fringes of society; they were men and women from the solid working middle class, the backbone of the country, people who do their level best to pay their bills and to meet their obligations.

Many work and work hard for employers who don't provide any health insurance at all. They can't afford to bear the costs on their own, so they simply pray for good health for themselves and their children. Some are insured but cannot afford the high deductibles and co-payments necessary to use the coverage.

A large number of Americans are going without needed treatment. Still more aren't getting it in time to prevent more serious and costly complications.

We heard from families bankrupted by the illness of a child or a parent. We heard from elderly people who had lost everything they had worked for their entire lives. And we heard from many other working people and retirees who wake up every morning knowing that financial disaster and poverty are only an illness or an injury away.

Clearly, the system is in need of fundamental change.

For instance, we cannot continue to punish employers who provide health insurance for their workers. As it stands, they are forced to subsidize health care for the employees of their competitors who gain a cost advantage by refusing to provide such coverage.

We cannot continue to penalize small employers and those with older, more experienced workers by forcing them to pay more for coverage.

For the vast majority of workers, free market solutions to the health care crisis have meant either increased cost shifting, reductions in benefit, or no health coverage at all.

It is time we admit that placing such a low value on a healthy and competitive work force has done virtually nothing to help us to rein in costs, which continue to soar upwards of 20 percent annually.

The United States spends at least 40 percent more of its gross national product on health care than any other industrialized

nation and as much as 70 percent more than our major competitors in the world market, yet these are Nations that guarantee basic health services to all of their citizens.

My lengthier version of this testimony, which I have submitted for the record, contains further details on AFL–CIO's basic goals for national health care reform, as well as some specific proposals on how to achieve them.

Essentially, we favor a uniform national cost-containment program that establishes rules for all payers, public and private, and puts a cap on the rate of increase in total health care costs.

We urge the creation of a core benefit package to which all Americans are entitled.

We want all employers to do their fair share and contribute to the cost of care.

We have to put an end to the patchwork quilt of Federal and State programs and establish one Federal program for the elderly, the poor, and the unemployed, and we advocate other specific proposals dealing with the problems of retiree health care and administrative waste while striving to improve the quality of care.

A good start, for example, would be to implement the recommendations of the majority of members of the recent Coal Commission, to assure active and retired miners access to health care.

Congress could also move to stop the shifting of costs to Federal workers participating in the Federal Employees Health Benefits Program.

But we cannot end there. Any solution will have to be comprehensive and include provisions for the health care of all Americans.

We have long passed the stage of quick fixes and voluntary efforts. Nothing short of full-scale reform will solve this problem.

In considering our proposals, I ask that you and your colleagues remember that they are not hardened in stone; we are in a negotiating position and are prepared to work with you, your staff, and all in the health care and business communities who share our basic goals regarding cost, access, and quality.

But we have got to move now on a full-scale program of national health care reform. Our Nation demands it, our people deserve it, and our future depends on it.

Thank you, and I will be happy to answer any questions you may have.

The CHAIRMAN. Thank you.

[Mr. Kirkland's prepared statement appears in the appendix.]

The CHAIRMAN. Mr. Kirkland, we certainly agree on a desperate need for improvement in accessibility of health care and cost containment.

In turn, we have the problem of paying for it, and how to do that in a time of severe budgetary constraints. Some members of this committee and some members of the Administration are talking about putting a cap on the exclusion of employee-provided health care benefits from the individual income tax. Dr. Reischauer has estimated that that exclusion now costs $56 to $58 billion in Federal, State, and local taxes in 1991.

What are your views, insofar as capping the exclusion as a means of financing the expanded Federal program that you are proposing?

Mr. KIRKLAND. I do not believe, Senator, that that is the proper approach or one that gets us toward our goals. It may be another act of financial expedience. You are talking about revisiting an issue that we have struggled over in connection with the tax reform, and I am not particularly anxious to revisit it.

I do not think our position on that would change one iota, and it does not address the real nature of the problem and the need for a comprehensive approach to health care reform, and I am sure there are many other approaches to the financing of it that are far more suitable and appropriate.

The CHAIRMAN. Well, that is what we will be seeking, of course, and it is not easy choices we are facing.

Mr. KIRKLAND. Yes, sir. I understand that.

The CHAIRMAN. You advocate establishing a national cap on the rate of growth in health care spending. How would the mechanics of that kind of an approach work? What would you have to give up in the process?

Mr. KIRKLAND. Our approach would contemplate and urge the creation of a national commission, which of course would have representatives of the appropriate arms of government on it but would also include consumers and representatives of the general public. The function of such a commission would be to oversee the negotiation of budgets, including capital budgets, on a national basis.

One of the most important sources of the escalation of costs is capital expenditures, where now decisions are made on quite an irrational basis and without an opportunity for careful study of the appropriateness of those expenditures, and also negotiated budgets and cost ceilings and caps with the provider community.

This could be approached in a number of ways. In the case of conventional indemnity insurers, fee-for-service providers, then I think it would contemplate and would have to contemplate negotiated rates for diagnosed procedures.

In the case of HMO's and preferred-provider organizations, I think the negotiations could proceed in a different way that would allow flexibility within negotiated budgets.

But that would be our essential approach. Effective cost containment must be a central part of the health care program.

The CHAIRMAN. No question about that. Right.

Senator Packwood?

Senator PACKWOOD. Was there a time when the AFL–CIO was recommending purely national health insurance in a more traditional European sense?

Mr. KIRKLAND. Absolutely, and I was one of the chief proponents of that system. I go back some 40 years of ardent advocacy of national health insurance—we didn't call it that in those days, but what is commonly now known as the "single-payer system." We used different terminology in the original versions, and I appeared on many a podium advocating the Wagner-Murray-Dingell Bill and that approach.

And if you gentlemen would tell me that you have the votes on this committee and in the Congress to place such a program into force, I would be as delighted as one could possibly be.

Senator PACKWOOD. Oh. I was hoping that Ms. Ignagni had had a good effect on you and had changed your thinking.

Mr. KIRKLAND. History has taken its toll on me, and the enormity of the problem has grown up around us and has become so pressing that I think it is absolutely urgent that we have action now. And I am convinced, to get action now, we must approach it on a basis where we can develop a broad enough basis of support to make the legislation possible.

Senator PACKWOOD. The Murray-Wagner-Dingell bill was sponsored by the current Congressman Dingell's father, was it not?

Mr. KIRKLAND. Yes. That is correct.

Senator PACKWOOD. And he has been gone since 1956.

Mr. KIRKLAND. Right.

Senator PACKWOOD. I take it, now, you are supporting a mandated system of some kind, not unlike the present Kennedy bill or, ironically, not unlike the Nixon bill 20 years ago, where we'll say to all employers, "Here is a core level of benefits you must provide."

Mr. KIRKLAND. I believe that would have to be a part of the health care reform package.

Senator PACKWOOD. Yes, I didn't mean that as solely.

Mr. KIRKLAND. However, Senator, if we were to mandate coverage on employers, I think it is a collateral responsibility to create a package of benefits that is cost efficient, that they can secure, without having to go just into the general market as it now exists for small employer coverage, which I think is excessively expensive and fraught with difficulties.

So I think the collateral part of it, if we mandate, has to be the creation of a core package that is economically available to those employers.

Senator PACKWOOD. I could not agree with you more, including whatever cost containment we can come up with, hopefully successful.

Mr. KIRKLAND. Yes.

Senator PACKWOOD. But I want to ask you this question:

We mandate a package which we finally agree upon as fair—labor says it is fair, business says it is fair, and therefore you are not going to have some employers having to pick up extra costs—would you be willing to say, if that package was mandated, that that is all an employer had to provide? Or could you then bargain above that?

Mr. KIRKLAND. Oh, we would retain our right to bargain above it, Senator.

Senator PACKWOOD. I was delighted with your answer to the Chairman's question. And in bargaining above it, those costs would still not be taxable as income to the employee.

Mr. KIRKLAND. Correct.

Senator PACKWOOD. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Just one quick question, Mr. Kirkland. You talk about, in your national approach, a Federal approach towards cost containment.

Mr. KIRKLAND. Yes.

Senator ROCKEFELLER. I would ask you to consider, for a moment an all-payer approach that was administered by the States as opposed to the Federal Government. One reason being that States have constitutionally mandated budget-balancing requirements. They are under incredible financial pressure and might be more effective with purchasers, providers, and consumers, et cetera, than the Federal Government. I would be interested in your thoughts on that.

Mr. KIRKLAND. Senator, I believe that there is an urgent need for a uniformity of regulation and the requirements that may be imposed upon providers, and there is also a need for simplification and streamlining.

I do not think a State-by-State cost-containment regulatory system would achieve those goals or be the most desirable way of approaching it.

Senator ROCKEFELLER. What if the States were told that they had to do it, but the States were allowed flexibility to respond to local needs.

Mr. KIRKLAND. We have had some experience with that, sir, in the Medicaid program, and I think the consequences of that don't commend that approach to us. The extraordinary differences in payment levels and procedures is, I think, a disgrace.

Senator ROCKEFELLER. I agree with you about Medicaid. Massachusetts, on the other hand, and Hawaii have been successful. I am told that Governor Weld is faced by 68 percent of the voters who don't want him to rescind the plan that was put in place by his predecessor.

Mr. KIRKLAND. Far be it for me to shed much sympathy for the employer community by and large, but it seems to me that most employers, who are going to be the major players in this, in the administration of it, would much prefer to face a single set of well-understood practices and procedures and regulations and controls. It is a national economy, and in fact it is an international economy, which is one of the reasons this health care reform is so urgent.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Durenberger?

Senator DURENBERGER. I will pass, Mr. Chairman.

The CHAIRMAN. Senator Breaux?

Senator BREAUX. Thank you, Mr. Chairman.

Thank you, Mr. Kirkland, and your colleagues for being with us. I certainly recognize the long-standing commitment that the AFL-CIO has had to improving the quality of health care for working men and women in this country. It is a fight that certainly is extremely important, and congratulations for all the good work you all have done.

Some of the information that we are going to be hearing later on talks about a national poll that says only 10 percent of American people think that their health system works very well.

Mr. KIRKLAND. And those 10 percent are wrong, sir. [Laughter.]

Senator BREAUX. Over-optimistic, right?

But the same poll said that almost 80 percent said they are satisfied with the health services. From your contacts nationwide with the people that you all represent, is that telling us something? I mean, they are satisfied with it but they don't think that it works very well? Is there a distinction out there? Or is there a distinction without a difference?

Mr. KIRKLAND. I think it means that most people like their doctors and have trust in their doctors. That is a question above and apart from the question of the adequacy or economy of the entire system, which I think is an entirely separate question.

Senator BREAUX. Well, I was interested in one of your suggestions, and that was a suggestion to reduce Medicare eligibility to age 60, the point, I guess, being that it would spread the cost of the retiree health care over the entire population. It seems like things are moving in another direction: people are able to work longer, their life expectancy is longer, and Social Security is being phased in over a longer period for a more elderly person, over their life expectancy. It seems like your suggestion is running contrary to some of the things that are happening out there as far as reducing the age eligibility.

Mr. KIRKLAND. I would like to correct just one point: people are not working longer. The actual age of retirement is going down and has been going down for some years. We have made progress in eliminating discrimination on account of age and employment, and eliminating compulsory retirement rules and so forth, but that does not mean the actual age when people retire, for reasons of choice or disability, is not going down. It has been going down for some time, I think probably because of the evolution of pension plans and the fact that it has become possible for more people to retire with a tolerable income.

But the fact is that more and more people are retiring before the age of eligibility for full benefits and eligibility for Medicare; plus, their spouses may be younger and still cannot qualify for benefits until they themselves reach 65.

So I think there is a very strong case for reducing the age of eligibility for Medicare to more closely reflect the actual practice of the average date of retirement, together with the fact that this issue of health benefits for retirees has become an increasingly difficult issue for employers, and for unions in negotiating with employers, and a costlier matter.

Lowering the age of eligibility for Medicare would, I believe, constructively address many of those problems and relieve many of those problems, and it simply makes sense in terms of the realities.

Senator BREAUX. On this earlier retirement, you are not for term limitations by any chance, are you?

Mr. KIRKLAND. Pardon?

Senator BREAUX. I am just asking, on this early retirement, you are not for term limitations as part of that early retirement, are you?

Mr. KIRKLAND. If I may have the deck on that, sir, I want you to know that we are firmly in favor of retaining the democratic right of the American people to elect whomever they choose, as often as they choose. [Laughter.]

The CHAIRMAN. You make a lot of sense, Mr. Kirkland. [Laughter.]

I think that is a good point to close with. We appreciated having you. Thank you.

Mr. KIRKLAND. Thank you, sir.

Senator BREAUX. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

We have Dr. Robert Blendon, who chairs the Department of Health Policy and Management, Harvard University School of Public Health.

Dr. Blendon, we are very pleased to have you. If you would, come forward, please.

STATEMENT OF ROBERT J. BLENDON, PH.D., CHAIR, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, HARVARD UNIVERSITY SCHOOL OF PUBLIC HEALTH, BOSTON, MA

Dr. BLENDON. I am Bob Blendon. I think in the staff memo you said that my role is to be, "Doctor, what is politically acceptable to the public?" That is what the label is; that is what I will try to do.

What do I actually do? I run the only, at the moment, polling and health care center. What we do is collect every poll since 1934 in health care, reanalyze it, look for patterns. It goes like this: Fifteen hundred since 1934, 50 since 1988, and one every other week since the start of this year. That should tell you something about what is going on.

I am going to be more relaxed in my remarks. One, it is getting late; and, two, I want to have an apology to the committee ahead of time—everyone wants to know what Americans think, and they get incredibly angry when they find out—that is, I will present the views on the issues that we discuss, but you have to forgive me: people do have opinions on these, and they are often not the ones held within the Beltway.

So I am going to take six points, hardly going to look at that, and there are two I want to go back to, because principally we are missing what is driving the debate among working people, and I want you to leave with a couple of numbers around that.

The first point is, we are at a 40-year high in the public answering on polls that they want some sort of a national health plan. We are 40 points higher than the last year of the Murray-Wagner-Dingell bill, just to give you some relevance to it, and we are 20 points higher since 1982 on the same set of questions.

We have got eight polls in the last 2 years which have asked about the same question, and it is all the same bottom line: "Do you want to stick with the current financing system, or something else with more taxes?" Six to 7 out of 10, every time, including two in Canada—and I asked the one on Canada; nobody knew what we were talking about—they said, "I'll take it."

Just for those of you who want to get into this, since I am an academic I had to find out, "How could they have won Canada, and they didn't even know what it was?" It turns out they really think it is Medicare, and I will get to that later.

It turns out—you won't believe it—that Medicare is very popular among Americans. You don't believe that because you are the ad-

ministrative agent and complaint department for the nation's elderly, and your lives are overwhelmed with the problems of this program.

Out in the hinterland this is a very popular program, and, if everything goes to hell, you will be amazed at how many Americans would settle for Medicare for all of themselves. Now, it is not their first choice, and we will get to that, but it is an incredibly popular program.

And for the record, the Canadian program is called "Medicare."

Point number two: What is driving the polls is that we have scared the heck out of the working population with insurance. The inability of business or anybody to control health care costs has led to a perceived erosion, either losing your policy, cutting back your children, or in the benefits thereof. I want to get back to this, because this is the most important issue about the politics of this.

The bottom line is, if you don't address the concern of working people with insurance, you miss what is driving the whole insurance movement.

Three—and I will get back to this—Americans are incredibly dissatisfied with the way we finance health care and the cost control, and when you use the word "system," that is what they answer. And the "system" is: "I don't like the security of the financial system; I don't like the way we control health care costs."

When you go to the other question, which was, "In the course of the last year, were you satisfied with the care you got from your doctor or hospital?" Americans are very satisfied. They think the "care" personally from doctors or hospitals is quite excellent. We have known that for more than a decade.

But since this is the Finance Committee and I am in the polling world, I will give you the analogy of this: If I ask Americans what they think of the banking system, they are scared to death at the moment, particularly savings and loans. If I ask them about the integrity of bankers, they are now below the funeral directors. I hope no one here is a banker by trade.

The third question is, if I ask them if they are satisfied with their last contact with a bank, they are, extremely, and that is due to the automatic tellers. [Laughter.]

People think the system is incredibly responsive, and they love it; but don't mess up their fear about the savings and loans—they are not very happy about that.

That is exactly what we have here. They think our insurance system is terrorizing them.

The next point: Americans are not a blank State out there. I have problems with my academic colleagues; they invent new systems every day, and they say, "We will just go out to the hinterlands, and we will tell them how your insurance is going to be."

It turns out, when you poll over and over again, Americans have two solutions to the insurance problem: One is Medicare for everybody, and it is split that way. That is, Americans could buy the idea of gradually just bringing Medicare down to the rest of the population.

And it has all these trade names in this town that the public wouldn't understand: "payer, play, mandate"—no man in the street would know what that means. But what it means to them, in

English, when you are a pollster, is: "How about every job coming with insurance?" Now, Americans like that. And it is neck-and-neck whether or not every job comes with private health insurance, and the neck-in-neck is, "Gee, it is like workmen's comp, Social Security, and unemployment. Every job comes with that; so should Prudential."

A fifth point: Taxes matter. When you throw taxes in, Americans will shift where they stand on this issue. This and education are two areas where they are willing to pay something. The "something" is, in my terms, a hundred-bucks-a-head, $10 billion program. I can deliver that tomorrow. No problem. With $200, you are in real trouble. So, this is where we are.

Now, this is very important. Given, as I said, that there was a split between Americans out there who could buy Medicare for themselves and a "private payer-player mandate," the jargon in town, when you show them taxes, they like Senator Rockefeller's proposal a little bit better. [Laughter.]

You find out what the next poll is.

And you answer is, they are very tax conscious.

Now, I have got to give a little bit of advice here. It turns out not all taxes are the same. If I were to go back to Harvard with just reams of data and say, "How would I get the most hated tax, so people threw eggs at me?" I would have a surcharge on the income tax. That is what my research would do. It would almost say that for the last 15 years that was the most unpopular thing, out of wartime, that you could ever have conceived of.

How about if I wanted a popular tax, one that was acceptable? Well, the easy one, that we wouldn't even need today, would be if we could get enough money out of sin taxes. I mean, people really think cigarettes should sell for $75 a pack, and hard liquor should be about $100, but not beer—it is an "American beverage." So that is a different issue.

But we can't get that.

What is the next one on the line? The next one—and every time I talk to Republicans the staff says to me, "Bob, don't say it; they won't ask you back in." The next one is the dirty "E" word, "employers."

The average American was told in 1940 that the employers should pay a share of the premium. They believe it. They really took your word for it. There is no survey that says, "How do you pay for it?" that doesn't come back, "I split it with my employer." They can. The question is, do they send the check to Medicare, or do they send the check to Prudential—that is non-decided, to a man—but every single survey says, "Employers split the contribution with me." Then you get to this issue about the next level, which are sales taxes, and the bottom of it is income taxes.

I will answer somebody's question about the employer benefit tax and how it is, and we can get it into a question. If you want to take a lot of Maalox, try to get rid of that cap on that deduction. For reasons that aren't clear to me, it is unbelievably popular, more popular than the charitable deduction, in terms of people's minds. It is not only popular among labor, it turns out it is with business leaders and the man in the street. It will be a tough one—not impossible, but a tough one.

Now, two other quickies here that have to do with the issue of Medicaid; that is, outside of this capital and Harvard.

It turns out that Medicaid is looked at as a welfare program by many Americans, and what we have is our self-employed and part-time people who can't get into a full-time employed system. The last thing you ever want to do is tell those people that the welfare system is where they should buy into insurance. There is absolutely no support for a dramatic expansion of the Medicaid program. There is support for some expansion for low-income, part-time workers, self-employed people, but not building around a welfare system.

And there are many people here from the South. We could spend hours discussing the views of working low-income Americans about Medicaid and welfare in the South. It is hostile; it is angry. It is not the program to try to build expansion.

These are the points.

I want to get into one section, and it goes like this. The most significant political number is as follows: that is the 33 million number doesn't explain the political issue that is going on. The number that explains it is that in the course of the last 2¼ years, one in four Americans will have been without insurance, for one point in time. So, what you have is one in four people who are cycling in and out of insurance. It is scaring them to death.

Also, I want to alert you to what will sound researchy but is a very serious political issue: On all polls of employers, they say that the one success they have had in cost containment is in increasing co-insurance and deductibles—that is, they save money; they are not paying the same amount in benefits. On all surveys of people who are employed with insurance, they say that their co-insurance deductible payments have gone up. However, the Department of Labor survey says there has been no change.

So what you find is that people, one in six, say, "My employer cut my benefits in the last 2 years," one in six say they are now paying 40 percent out-of-pocket, and we have had a 40 percent increase in the number of kids without insurance, all of whom are the working parents.

So I have a slide in here which goes like this.

The CHAIRMAN. Doctor, I am going to have to ask you to summarize, as we have a number of witnesses yet to testify.

Dr. BLENDON. Yes.

My last point is quick. The employer cuts benefits. Sixty percent of the people say, "My insurance is okay for today," but only 30 percent say, "My insurance will cover me for a bill in the future." Sixty percent say, "I don't think the system is going to be able to do that." The same 60 percent says, "I want a national health plan financed by taxes."

So what you have is the cut in the benefits for insured working people is getting people to say to Gallop and Harris, "I will take a national health plan, even though I don't know what it is."

The CHAIRMAN. Well, that is quite a statement, and I am going to look forward to reading your statement, and taking my Maalox with it. [Laughter.]

[The prepared statement of Dr. Blendon appears in the appendix.]

The CHAIRMAN. You were talking about how the American people want some major change, and may even be willing to pay part of it. And yet, we also hear that they are satisfied with the medical care they personally are getting.

Now, Dr. Reischauer was talking about some of the trade-offs, some of the things that might happen in regard to that, some of the sacrifices in restructuring a health care system: a slow-down in medical research and development of new technologies, waiting longer for some high tech medical procedures, increased limitation on the choice of doctors and other health care providers. When you get into those kinds of technicalities, is there an understanding by the American people? Are they willing to accept those kinds of trade-offs?

Dr. BLENDON. The answer is, no, not today. They are willing to take the soft trade-offs; that is, most of what you have done in Medicare—DRG's, relative value scale, utilization review. And, back to Senator Rockefeller, managed care is agreed to, whatever it may be, by the man in the street, by everybody in the business and the labor community. That is the level. They are not for rationing—with the possible exception of poor people, and we could get into that later.

The CHAIRMAN. Well, let us get into this rationing issue. Based on your understanding of your polls, what aspects of the health care system are of the deepest concern for the American people? If we have a limitation of financial resources, where do we go to concentrate on the basic package? What should be in it, do you think?

Dr. BLENDON. Let me just represent the views of people here:

First, they think the place is loaded with duplication of facilities. They believe we have an incredible amount of empty, unused, duplicative facilities.

Second—and the American Medical Association only invites me when they need their ulcers provoked—they think doctors get paid too much in this country. It is a very big symbolic issue. It is not a lot of money.

Third, they think a lot more can be done on an outpatient basis than currently is.

That is the level of where people are. They are not at the level of the hard decisions of the ethics and the rationing. It is just not there. And if that is what it has to be, it is a very different public response.

The CHAIRMAN. Yes.

Senator Packwood?

Senator PACKWOOD. In your statement, where you say more than 75 percent of the Americans are satisfied with hospital services and 85 percent with physician services, you mean "services" but not "costs," I take it.

Dr. BLENDON. Right. On the next page here in the testimony, right after the one which says, "We hate our system," comparative countries, "but we like our health care," the same survey asked them how they felt about the cost of care in their country. As you can see, Americans think the costs of hospital care are outrageous, where the Canadians and Germans don't. The Americans think the cost of physician care is outrageous, but the Germans and Canadians don't.

So, it is the cost of care. They do not believe it has to be at the level that it has to be.

Senator PACKWOOD. Well, let me ask this question again. I talked about anecdotal experience. I get very few questions about health insurance coverage at the coffee shacks of businesses that have what normally might be regarded as an "adequate" health insurance system, because the employees are not paying most of these high costs. That doesn't contradict any evidence you have, though, or even their feelings, does it?

Dr. BLENDON. Absolutely. What they are scared about is the potential loss of insurance.

Senator PACKWOOD. Oh. Okay.

Now, if we passed a national mandated health insurance bill so they felt it was like unemployment or worker's compensation or Social Security, would that relieve that fear?

Dr. BLENDON. The answer is, yes. We surveyed 10 European countries and asked them about their health systems, and in every one of them they were happier than ours. We believe what that meant was, "You have relieved me of this principal fear, that if I have a terrible cost of illness, I'll never have to pay it," and you can't lose your insurance in any of those 10 countries.

Senator PACKWOOD. Now let me ask you a second one. We mandate it, and we say, "Here's a core package of benefits," so whether labor bargains above it or not is another matter. But there is a core package that makes most people feel comfortable.

In addition, if we could now say, "Okay, you are never going to be faced with a $10,000 hospital bill," or whatever, maybe we put a COLA adjustment on it to make sure it doesn't eat us alive in 5 years, would they then be satisfied to pay the first $500 or $1,000 of their expenses?

Dr. BLENDON. Well, the pressure always will be to reduce risk. There is, in the American character, this desire to be risk-averse. So there is no question.

I believe they would buy a basic plan tomorrow, because people are so scared about losing it. But 5 years from now, on the hustings we will find people saying, like the minimum wage, "Raise the level of what the basic benefit is." This is no question; people are risk-averse. But they would buy the basic plan today.

Senator PACKWOOD. I understand your answer, sir, but would they trade it off for a deductible of the first $1,000 of medical expenses, no matter what, in exchange for a guarantee against catastrophic costs?

Dr. BLENDON. The polling always had, in previous years, that catastrophic never carried the day, even though people wanted some more front-end protection. So I don't think a very large catastrophic program alone would carry the day.

But I think you could have one level down from the thousand, which wasn't as scary. I mean, $1,000 for someone at $15,000 is very significant. And you could carry the day if the deductible wasn't at the size that it was, at that scale.

Senator PACKWOOD. And you might even be able to adjust that for inflation.

Dr. BLENDON. Right, absolutely right.

Senator PACKWOOD. And you would remove the fear they have about this, "My insurance isn't going to be there; I am going to lose it." If they felt confident about that, we might have a system that they would accept.

Dr. BLENDON. Right.

Just on the positive side, on the tax cap, the only chance you would ever have to do something about the tax cap which had some acceptability would be if it was discussed right at that moment when everyone was guaranteed insurance, and you say to them, "Well, it will only be up to $2,000, but you will never lose your policy." Then I think, with middle class, working Americans, you will have a negotiated agreement.

Senator PACKWOOD. By the "tax cap," you mean, "Above this level you will be taxed?"

Dr. BLENDON. Right. But it has to be something that middle class Americans can see.

Senator PACKWOOD. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Dr. Blendon, this is going to sound political, and I apologize for that, but back in the 1988 campaign President Bush said that health care was not showing up in "his" polls as being on the minds of the American people.

If you are looking at 1992, with your crystal ball, do you think that situation has changed? And do you think it will be a factor?

Dr. BLENDON. I think it will be a factor in congressional races, but not in presidential races. Twenty-one percent of people who voted for Governor Dukakis and Senator Bentsen said that health care was a principal issue in determining their vote in the 1988 election.

So, when you get rid of the national issues, which tend to be foreign policy, inflation, crime, and raising your taxes, the problem is, it is the second level. However, when you get to polls on Congress and Senators, some of those issues that they look at the President for are not the same issues that you see in the voting for the Congress or the Senate, and it is likely to be an important issue in many of those races. But the President, quite frankly, can escape it if he does nothing in the next 3 years.

Senator ROCKEFELLER. It is traditionally said that pocketbook issues are what govern a presidential vote, and some might suggest that the cost of health care and the prospect or the fear of the future cost of health care is sort of "the" fundamental pocketbook issue for the next or 20 years.

Dr. BLENDON. It is one of the major. I don't want to reduce that, because if the President's polling people were there, they would say, "Tell it straight, Blendon. There are five issues that people worry about in presidential elections. Health care is not on that five; it is in the next tier with education and environment. They influence, but the don't finally decide.

Senator ROCKEFELLER. Gotcha.

You said in your testimony, "If supporters of change are divided about the form the change should take, the will of the minority, that wants no change, could prevail." I am not asking you for a response on that.

I assume you are familiar with the Pepper Commission.

Dr. BLENDON. Absolutely.

Senator ROCKEFELLER. I would be interested in how the Pepper Commission recommendations measure up in terms of the five principles that you refer to on page 6 of your testimony, in terms of a national health insurance proposal.

Dr. BLENDON. I think it is very close. The issue of the tax package and the acceptability of how it is phased in is incredibly important. Until Americans know how it is going to be paid for, that is so critical in deciding whether or not they will play this game. And that was not all settled, as I recall, at least in the Pepper–I, on the financing levels.

Then, second, what we don't know from polling yet—and there are a number of groups now polling—is, "Do you need long-term care to be part of the package to get an under-65 bill enacted?" And that isn't at all clear, because that is a very expensive addition to the initial cost for taxpayers, and it will scare some people. We don't know yet from polling whether or not that is, "You should do it in stages," or "Just have a bill that covers the under 65."

Senator ROCKEFELLER. I understand exactly what you are saying; but, in terms of the phase-in, et cetera, et cetera, you have five substantive——

Dr. BLENDON. Absolutely. They correspond.

Senator ROCKEFELLER. The phase-in, the benefits, the compromise.

Dr. BLENDON. Right.

Senator ROCKEFELLER. A final question. You said that cost-containment ought to focus on providers of care—doctors, hospitals, et cetera—not on the individual. My question is: What about managed care? Does that mean if we made a much more strong effort to enroll people in managed care programs, that would be viewed negatively by the public?

Dr. BLENDON. No. At the moment, if you don't move the individual from a doctor or a hospital, or there is a wide range of choice—you are limited to a third of the doctors in Boston—people don't have any problems. Where they have problems is where you say there is one group of doctors, three hospitals, and that is it. They are not prepared to do that. They are prepared to go to a more limited selection, but not to a very narrow one, what would be traditionally a closed-panel HMO involvement.

Senator ROCKEFELLER. Thank you, Dr. Blendon.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Durenberger?

Senator DURENBERGER. Yes, Mr. Chairman.

Bob, it would appear to me that the difficulty with the public today is that they don't understand the difference between health insurance and insurance. When I go out there and say, "How many people in this room don't have fire insurance?" no hand goes up, and I say, "Do you know that only 2 percent of you will ever have a fire, and 98 percent of you are paying for it?"

When I explore with people the notion of insurance, it comes home quickly to me that they don't think about insurance when they think about the stuff we are debating here all morning long.

When I look at the inserts you have in here from business and health, how companies will trim health programs to hold down costs, all of it is cutting back on the cost and none of it is in changing the benefits, or very little of it is changing the benefits.

So, isn't it right that one of our problems here, as we are trying to determine whether it is core benefit, or whatever it is—and that is probably going to be the heart of this issue—is whether or not we can sell the American public on the notion that what they need is financial protection, that they don't need to continue a couple-of-generation tradition of having all their bills paid, or paid in part, but at least making sure they have got a chiropractor, they have got a dentist, and all the rest of these sorts of things?

Am I making myself clear?

Dr. BLENDON. I think you could settle on a basic package, but what I have to just be honest about is, Americans are risk-averse. And when you ask them what is the ideal insurance arrangement they would like to have, it is a comprehensive plan, which is a lot more expensive than most academics or members of this committee, I believe, would want to have. So, that tension is just going to be there.

But there is a sense of realism, because people are scared about losing their policy or their children's policy, that you could negotiate within this climate.

Senator DURENBERGER. Do you have a way of determining why that is? Because I sense the same thing. I talked to a young man the other day who was on staff, and he hadn't taken insurance because the deductible had gone up from $250 to $500. Or he was complaining about it, I guess that was it.

I said, "Well, what was the problem?" He said, "Well, I don't know that I can afford the $500." I asked him how much he made, and he made something in the neighborhood of $20,000 a year. He thought that somehow or other that was going to break him, to go from $250 to $500.

It just strike me that so many people, when it comes to health insurance—if you did that on automobile insurance, you wouldn't get the same reaction. If you do that on fire insurance, you don't seem to get the same reaction. But somehow, in health, you are getting a reaction.

Dr. BLENDON. All I can tell you from the academic research is that people look at this like they do the withholding tax issue; they will literally want to prepay all their future expenses and at the end of the year have zero. And there is this desire to literally prepay all of it.

Now, we still have the tax issue as unresolved. If we had no tax benefits, I am sure, as all of the research suggests, we wouldn't be as prone to it. But there is a desire to pay it in and having nothing out of pocket at a time of use.

Senator DURENBERGER. Have you done anything on the fairness issues, like, you know, the sinners. You talked about the "sin tax," but I mean "people who smoke a lot shouldn't get free hearts," or "people who drink a lot shouldn't get free benefits?"

Dr. BLENDON. The public is not punitive in any worked-out level. Where they are punitive is, there is a growing interest in having them pay more taxes on cigarettes. See, that is the way the public

would deal with this. The $17-pack punishes you and maybe pays for your heart transplant. That is the way they would like to go.

There is some public support for health risk assessing insurance, to provide incentives and penalize it. But there is no public support for anything draconian like rationing people's lives.

Senator DURENBERGER. Thank you.

The CHAIRMAN. Thank you.

Senator Pryor?

Senator PRYOR. Mr. Chairman, just so we will know—and I have been out of the room—are we going to continue over into the afternoon on the hearing? Or are we going to try to go right through?

The CHAIRMAN. We are going to go right on through.

Senator PRYOR. We are going to try to get through?

The CHAIRMAN. Yes. My problem is that a number of these other witnesses have plane commitments and schedules to meet.

Senator PRYOR. Well, let me ask just one question, if I might, to the doctor.

First, I think there is a fairness issue. Senator Durenberger was talking about fairness, but there is another fairness issue, and that is the distinction between your larger business and your smaller business, in how the tax code treats the deduction for the smaller business, say a 25 percent deduction versus a 100 percent write-off for the larger businesses.

I have always considered this an anomaly. I think Dr. Reischauer sort of addressed this issue to a degree this morning, when he said it appears to be that the larger the deduction, the more expensive or the more Cadillac-type plan.

I am wondering if you have any figures, or numbers, or theories on this. If we sort of gave small business the same treatment we gave the larger business, how would that change the playing field?

Dr. BLENDON. I want to duck that question. We had a problem this morning of asking Bob Reischauer, an economist, about polling, and asking me, who is a survey political scientist here, about the economic incentives. I would like to duck that, because I am not qualified to answer it.

Senator PRYOR. All right, sir. Thank you very much.

Mr. Chairman, I will yield back the balance of my time. I do have a couple of questions for the upcoming witnesses. Thank you, sir.

The CHAIRMAN. Dr. Blendon, that last answer was strictly refreshing. [Laughter.]

Dr. BLENDON. It doesn't happen in my place very often.

The CHAIRMAN. It doesn't happen around here very often, either. [Laughter.]

Thank you very much for your attendance. I must say, Doctor, I am taking your full statement home, and I will read it tonight.

Our next panel consists of Gary Kushner, who is president of Kushner & Co., Kalamazoo, MI, representing the National Small Business United; Mr. John Morley, president and chief executive of Reliance Electric, Cleveland, OH; Mr. Michael Peevey, the president of Southern California Edison Co., Rosemead, CA; and Mr. Don Summers, president of Austin Welder and Generator Service, Austin, TX, representing the National Federation of Independent Business.

Gentlemen, I apologize for the delay, but I thought we would continue on. I am sure that you have plane schedules to meet, and we can skip lunch.

Mr. Peevey, if you would, proceed, please.

STATEMENT OF MICHAEL R. PEEVEY, PRESIDENT, SOUTHERN CALIFORNIA EDISON CO., ROSEMEAD, CA, ACCOMPANIED BY DR. JACQUE SOKOLOV, VICE PRESIDENT AND MEDICAL DIRECTOR

Mr. PEEVEY. Mr. Chairman and members of the committee, it is a pleasure to be here.

My name is Michael Peevey. I am President of the Southern California Edison Co. Today I am accompanied by Dr. Jacque, on my left here, our vice president and medical director.

Southern California Edison is the Nation's second largest electric utility, providing service to over 10 million people in a 50,000 square mile service territory in Southern and Central California. We are intimately involved in providing and paying for health services for our 55,000 employees, retirees, and their family members.

I am here today to ask for a Federal response to the issue of escalating health care costs. We are concerned that the financing of health care in the United States is out of control. This country has the most expensive and the least accessible health care services of any industrialized nation, and we pay for it with the most fragmented, complicated, and intrusive financing scheme ever invented.

This financing scheme and the turmoil it created for both providers and purchasers is threatening the viability of health care services in our communities.

To start with, we are concerned about what this does to people. It is not just a problem that affects the 33 or 35 million uninsured; it affects everyone. The fact that there are 5 million Californians without health insurance makes us wonder about our own security. The fact that half of the Los Angeles area trauma hospitals have withdrawn from the trauma care system because of uncompensated care puts us all at risk, regardless of the kind of health insurance we have.

This growing chaos in our health care system also affects Edison's ability to control its own health benefits program. The unusually high health care inflation of the past decade quadrupled our health care costs, from $21 million in 1981 to $88 million in 1990. Toward the end of the eighties our costs were rising at a rate of 23 percent per year. We had to act.

In 1989 we implemented a series of innovative health care management strategies, creating one of the first corporate managed health care systems in America. Our strategies were aimed at encouraging our employees to take more responsibility for their own health, developing financial incentives for the use of efficient, high quality providers, and managing utilization to minimize unnecessary, inappropriate, and harmful health care.

Our efforts have borne fruit. In a 2-year period, 1989 and 1990, we spent approximately $38 million less than if we had not imple-

mented these programs. We believe we have brought our long-term trend down—this is the trend in health care costs—to the 10 to 12 percent range. This is a good trend rate for an employer; but still, high enough to double our costs every 6 years.

In an effort to manage our health care plans, we have discovered the limits of our power to influence health care costs. The irony is that we are trying to slow a nationwide increase in health expenditures with our own isolated efforts. It is as if we were living on the banks of a river with a flood coming. We went out and sandbagged only our own home and then wondered why our property ended up under water.

For some reason, with health care inflation, this society seems content to let everyone bail the water out of their own yards rather than acting collectively.

Managing nationwide health care costs requires a partnership between the private and public sectors. Edison will provide health care to our employees and manage utilization of health services. From the Federal Government we need greater control over the external factors that we cannot influence.

The first thing we would like to see is an end to cost shifting, as pointed out in today's Washington Post editorial.

Cost shifting not only causes small employers costs to soar, it also contributes to an overall acceleration in provider charges and a growing confusion about who is paying for what.

Part of the answer is paying fairly for Medicare and Medicaid beneficiaries, which means raising additional Federal revenues. Let me assure you: Edison would rather pay health care costs for the poor and the elderly through broad-based and equitable taxes than through the hidden charges we now pay on our health plans. You can't just end cost shifting by paying providers more for Medicare and Medicaid; you are going to have to give us the tools to control what we pay, as well.

We would like to see the Federal Government create a system of all-payer rate negotiations, similar to what Maryland has in the hospital area, to ensure that small and large payers, private sector and government, can all benefit from the low rates negotiated by the largest purchasers.

We also would like to see an overall limit set on increases in national health care expenditures. A national target will give us all a yardstick for measuring our progress toward cost containment, and it will give all employers a sense of predictability in our health care costs.

In the end, however, much of this effort will be futile unless something can be done to constrain the endless increasing supply of health care. We applaud HCFA's efforts to limit excessive Medicare payments for new capital and technology; but we urge you not to keep the benefit of this to yourselves. All payers need to be represented in the effort to reduce hospital capacity and efficiently allocate new technology, or the cost for new equipment will just be passed along.

Finally, we want to give our employees good health care, and that means being assured that a dollar's worth of cost is buying us a dollar's worth of health care.

From the Federal Government we need the tools to enable us to do the job. Generous funding for outcomes research, encouraging the development of medical practice standards, and enabling payers to remain free to identify, contract with, and reward providers who can deliver appropriate high-quality medical care.

Comprehensive reforms like these may take years to accomplish. Right now it is important that you send a message to consumers, employers, and providers that you are serious about controlling costs. No matter which reform approach you select in the end, all reforms will have to start with better information and a more systematic analysis of health trends.

So I would urge the Congress to send us this message about cost containment by enacting, this year, at least the six building blocks for reform which I have detailed in my written statement. They include a standing national council on health care, a uniform national claim form, a national health care claims database, a database on capital purchases, a national technology assessment agency, and a Federal statutory support for State and local experiments aimed at ending cost shifting. These building blocks could be an inexpensive way to get started on the road to comprehensive reform.

If you do nothing, a decade from now Edison's health care budget will be three to four times what it is today, and we won't be the worst case, by any means.

Americans need a sense from Congress of how this Nation is going to deal with the problem of rising health care costs. We have seen decades of brownian motion on health care, with no policy to manage our resources or solve our difficult problems.

What we need most from the Federal Government today is the courage to set a clear course for the future, a future that will bring about predictability and manageability to help us work together to ensure good health for all Americans.

Thank you very much.

The CHAIRMAN. Thank you, Mr. Peevey.

[The prepared statement of Mr. Peevey appears in the appendix.]

Gentlemen, Mr. Peevey has a very major corporation, with sophisticated management and a broad-gauge management. He is, incidentally, a friend of mine. What I have tried to do in these hearings is to have his testimony and then to contrast it, to a degree, with the problems of smaller businesses are facing, the tough problems they are facing in the way of costs.

So our next witness, Mr. Summers, is the president of Austin Welder and Generator Service in Austin, TX, and he is representing the National Federation of Independent Business.

Mr. Summers?

STATEMENT OF DON SUMMERS, PRESIDENT, AUSTIN WELDER AND GENERATOR SERVICES, AUSTIN, TX, REPRESENTING THE NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Mr. SUMMERS. Thank you, Mr. Chairman, and gentlemen.

I can't express to you how honored and pleased I am to have been invited to speak to you today.

My name is Don Summers. My sons and I own and operate a small business in Austin, Texas.

By the way, Mr. Chairman, I bring you warmest greetings from the capital of your home State.

The CHAIRMAN. Thank you very much, Mr. Summers.

Mr. SUMMERS. We have nine employees, including my sons and myself, and we are in deep trouble. We opened our business in 1978 and since have grown some. About in 1980 we began paying for health insurance for all employees. That is my moral responsibility, to see that my people are cared for. I have been assigned that.

I spent the first 46 years of my life as a youth and as an employee. Since then, I have become an employer. My responsibility to myself is to provide for my employees the way I always wished I had been provided for.

When we started out, our first year in business, in 1978, our gross income was $16,500. Last year our gross was $610,000, and I am rather proud of that. For nine people, that is not a bad gross.

Let me tell you what we do. We fix welding machines. We deal with industrial things. We also take care of the emergency generators at the hospitals, the nursing homes, supermarkets, manufacturers, and office buildings in the Austin area. One generator that we take care of is 900 kilowatts. That is a big generator. We have done work for the Army; we have done work for the Air Force; we have done work for Motorola and numerous other companies. I say a lot of this in pride; you can see my ego showing.

But between 1989 and 1990, my health insurance costs went crazy. We found, in May of last year, that the payment for our company health insurance premiums were exceeding our bottom-line monthly profit. That can't last.

My accountant and I spent a couple of months trying to find an alternative. We immediately increased our deductible from $300 to $600, but that wasn't sufficient. There were other carriers that we interviewed. There were HMO's. There was much time of strenuously trying to find a replacement contract that would keep myself, of course, and all of our employees covered.

Finally, in August of last year, I had to call my people together and say, "I can no longer pay for your health insurance." I didn't want to do that, but I had to do it. We cancelled our health contract, and we cancelled our life insurance, because we couldn't afford it. Now there are nine families with no health insurance.

If you will look at the last sheet that I gave you, you will see how those costs escalated. Our total bill in January of 1989, for the month, was $911.13. The total bill for May 1 of 1990 was $3,757. I can't do it.

There have been all kinds of suggestions put forward this morning. I don't know what to tell you I would like to see. It scares me to think about a national health insurance, but I do believe this: I believe that the small business is the heart and soul of the American economy.

There are 210,000 small businesses in Texas with less than 20 employees—210,000 of us—and we are all in the same boat; we are all hurting because of health insurance.

I have to come face to face with my people every day. I don't have a board of directors to hide behind and pass down decisions. I have to go out in the shop, and I have to say, "Hi, Greg! How are you and Sally today?" Greg says, "Oh, I'm doing okay." "How

about you, Wade?" Wade says, "Oh, my wife's pregnant." Oh, Lord. A 21-year-old man with a pregnant wife, making $10 an hour. Lot's of luck, young man.

Something must be done. I apologize for going over, Mr. Chairman, but I feel so strongly about this.

The CHAIRMAN. Well, that is a poignant message.

Mr. SUMMERS. I need your help.

The CHAIRMAN. Yes.

Mr. SUMMERS. Thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Summers appears in the appendix.]

The CHAIRMAN. Our next witness is Gary Kushner, who is president of the Kushner Co. in Kalamazoo, MI.

Mr. Kushner?

STATEMENT OF GARY KUSHNER, PRESIDENT, KUSHNER & CO., INC., KALAMAZOO, MI, REPRESENTING NATIONAL SMALL BUSINESS UNITED

Mr. KUSHNER. Thank you, Mr. Chairman.

Please accept my written testimony into the record.

I have the unique opportunity to both be a small employer and to be involved in advising other small to medium-sized employers in the design and construction of their employee benefit packages. So I am able to relate to this issue on a number of different fronts.

You have heard this morning of the concerns in general with health care from three perspectives: the cost, access, and a quality perspective. Those issues are all exacerbated tremendously when it applies to the small employer community, for it is the small employer who historically and today has borne the brunt of the cost shift.

All of the players involved in health care today can be apportioned some blame. We know—we heard the statistics this morning—that today 13 percent of our gross national product goes into health care, that by the year 2000 it will be almost 20 percent. But there are many problems, as well.

Most Americans have few if any incentive to shop for less expensive health care. Providers have even fewer incentives to provide that. If we are to solve the health care crisis today, we must bring greater individual responsibility into the system if either the cost or the access problems are to be solved.

Clearly, cut-backs in Federal spending on Medicare and the under-funded levels of the Medicaid program are serving to shift these costs away from the Federal and State Governments and on to private payers. In order to bring equity into the system, the government must in fact own up to its own responsibilities for the elderly and the poor.

Small business has its own unique set of problems, as well. The current health insurance marketplace makes it very difficult for small groups to find and to keep affordable coverage for their workers, and to stay adequately insured over a sustained period of time. On average, small employers pay as much as 40 percent more for the same coverage as their larger brethren. Small businesses

may have under-insured employees because of pre-existing condition limitations, which are more prevalent in small group markets than in others.

At the National Small Business United we are working on a proposal that would address many of the concerns of all in this country as it relates to health care.

First, we would propose that State mandates should be preempted and replaced with a very basic Federal package which all small employers could buy into. This package would have a consumer-type structure, in order to encourage greater individual responsibility and at the same time make premiums affordable.

The insurance system should be reformed to spread risk across greater numbers. We should make efforts to reduce the degree to which small employers undergo individual health care screening for insurance. We must also find ways of limiting the year-over-year increases in health insurance premiums for those who may get sick.

The insurance reform proposal is made less problematic by the imposition of a rule that all individuals must be enrolled in a health plan. This rule should reduce the rolls of the uninsured and lower the adverse-selection problems traditionally found in spreading health insurance risks.

Costs need to be further contained by reforming the malpractice system, in order to cut back on unnecessary care and malpractice insurance premiums.

In addition, health expenditure review boards should be established at the Federal, State, and local levels, to control overall health care costs by reviewing expenditures and arbitrating rates.

Pricing health care provided to those in small groups according to Medicare rates may go a long way in bringing meaningful cost containment to the small employer marketplace.

Lastly, issues revolving around competition in the health care industry, and as they are restricted by some of the current anti-trust problems, need to be addressed.

Coming from the State of Michigan and living in Kalamazoo, I am pleased to look up at my skies in the evening and know that, of the 90 helicopter services in the nation, two are housed in Kalamazoo. Now, I am not sure exactly what that attests to, other than the duplication of services provided by our two hospitals; but clearly, the cost implications of that duplication can no longer be borne by any of us.

In conclusion, what I would ask for is a proposal that would address the concerns of all citizens in this country, first, to controlling costs of health care; secondly, providing access for those who currently do not have it; and third, ensuring the current quality and maintaining the quality of care that we now have.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Kushner's appears in the appendix.]

The CHAIRMAN. Next is Mr. John Morley, who is president and chief executive officer of the Reliance Electric in Cleveland, OH.

Mr. Morley, we are pleased to have you here today.

STATEMENT OF JOHN C. MORLEY, PRESIDENT AND CHIEF EXECUTIVE OFFICER, RELIANCE ELECTRIC, CLEVELAND, OH

Mr. MORLEY. Thank you, Mr. Chairman, and members.

I have been invited to speak today, really, on two subjects, one, what has Reliance undertaken to respond to its health care issues? and, two, to talk about a project that is underway in Cleveland dealing with this whole issue of quality health care.

By way of background, Reliance is a company with about $1.5 billion in sales. We operate throughout the world, and we have about 14,000 employees.

I also serve the Greater Cleveland Health Quality Choice Coalition as chairman of their Purchaser CEO Leadership Group and of the Coalition Steering Committee.

Before I get into the details of my comments, there is one key point I would like to make:

In the United States we have developed the wrong incentives for health care reimbursement. We pay for the quantity of care delivered, not the quality. When we search for a major driver of health care costs in this country, our pay-for-service reimbursement system lies at the heart of the issue.

Let me briefly talk about what Reliance has done in the health care area. We provide health benefits to more than 40,000 people, including our employees, retirees, and their dependents.

Health benefits are the fastest growing cost we have, and we are vitally interested in this issue; it is becoming company-threatening. Last year they were the company's largest buy next to steel, and this year they may very well be larger than steel. They have an enormous impact on our employees.

Today, 15 percent of the average American worker's total compensation goes to pay for health care. This compares to 3 percent in 1965. As a result, we have made two sets of changes to our health plans in recent years:

The first included pre-admission review, medical case management, and some increased employee cost sharing, aimed in part to encourage our employees to be better purchasers.

The second set of changes was the adoption of a preferred-provider organization network of doctors and hospitals, nationwide, effective January 1 of this year.

However, as positive as these steps have been, none offers the potential for quality and efficiency as the Cleveland Health Quality Choice.

When we look at some of these basic fundamentals, I think we can talk in terms of two basic issues:

One, patients and purchasers have no information on the relative quality of health care providers. When we need surgery or some other treatment, we don't have hard evidence as to which providers excel at the required procedure. Nor do we have much information on the efficacy of a procedure or the alternatives to that procedure or treatment.

Number two, the pay-for-service system punishes quality and efficiency. Doctors and hospitals are rewarded for high volume and inefficiency and punished for effectiveness and efficiency by the pay-for-service system of financing health care.

Data from the medical community itself paints the picture of a society burdened by extreme over-practice of medicine, with no standard measures of quality, no accessible means of determining the efficacy of procedures, and no mechanisms or incentives working to improve value to patients.

Based on this data, we believe that a quality-based competitive delivery system, with proper incentives furnished by private payers and, ultimately, by government payers as well, can produce efficiency or productivity gains in the health care system on the order of 20 to 30 percent. Even a 10 percent saving would yield somewhere between $60 to $70 billion in annual savings. We can use these savings to pay for improved access to quality health care for the millions of Americans who currently lack coverage.

The key to accomplishing this is to change the pay-for-service system of reimbursement. Can this be done? We think so.

Greater Cleveland Health Quality Choice is a private sector initiative that was first announced at the Pepper Commission hearings in Cleveland in 1989. It is a purchaser-led, intensively collaborated effort to drive productivity gains by making quality and efficiency the focus of our purchasing system.

Cleveland Health Quality Choice involves one of the most talented and committed groups of people I have had the pleasure to work with. The people making this program work are physicians, hospitals, and the business community, all working together on a voluntary basis to create uniform measures of hospital quality that purchasers can use to encourage patient choice of high quality, cost-efficient procedures. The system is designed to reward quality and efficiency with a larger share of the patient market.

Let me describe how we have done that.

The CEO's of Cleveland Tomorrow, an organization of 50 of the largest local corporations, combined with the Council of Smaller Enterprises to form a purchasers' leadership group. This large business/small business combination represents over 350,000 covered lives in the Cleveland area alone.

In response to this group's request, physicians participating through the Cleveland Academy of Medicine and the hospitals participating through the Greater Cleveland Hospital Association agreed to measure themselves under a common set of quality indicators. These indicators include patient outcomes, adjusted for severity and illness, and of patient satisfaction evaluations. The data will be released to purchasers for use in 1992, and in return, the employers in the purchasing group will marry the quality data with the employee health plans, to offer employees incentives to choose the quality providers. We will reward the quality providers with market share.

I think it is important to conclude by saying that the private sector is interested in working with the Congress in a public-private partnership to pursue these directions.

I have four specific recommendations:

First, I encourage you to continue the important funding of quality measurement research that you have underway.

Second, approximately one-third of all Medicare beneficiaries, approximately 10 million people, receive Medicare supplement benefits through their employers. As employer health plans change

from the pay-for-service system to the patient-choice system, I believe that a public-private partnership can find ways to extend quality-based reimbursement to the Medicare program.

Third, the major innovations being made in employee health benefit plans in Cleveland and elsewhere should result in productivity improvements that will make it possible for the public purchaser like Medicare and Medicaid to begin "buying in" to a reformed health care market on behalf of the poor and the uninsured.

Fourth, a number of Cleveland employers have developed proposed Federal legislation, the Patient Choice Small Employer Purchasing Group Act, that can significantly reduce the number of uninsured Americans without requiring any government funds. It is intended to stimulate the formation of small employer purchasing groups like the Cleveland Council of Small Enterprises that makes health insurance available to 10,000 small employers on behalf of over 125,000 employees and their dependents.

The CHAIRMAN. Thank you, Mr. Morley.

[The prepared statement of Mr. Morley appears in the appendix.]

The CHAIRMAN. I know that each of you have a number of questions you want to ask, but let us limit them, to the extent we can, and submit the rest in writing, because of the lateness of time.

Mr. Peevey, you were talking about a national expenditure target, so that we can stay within the limitations of what we think we can afford to spend for health care in this country. Let me ask you the same question I asked Lane Kirkland: Who would have the responsibility for administering that? What level? Would you give me a feel for how it would work?

Mr. PEEVEY. Well, there are varying degrees and varying levels it can be done at. I would like to have the States have as much autonomy and ability to innovate and all within the structure as much as possible.

Let me say—a little bit off on that point—this: We talk about one in six Americans not having health care, and we act as if they don't receive any health care whatsoever; but that is a misconception in many cases. They don't receive the kind of care they should be getting, but they do get emergency care, and the rest of us are all bearing the cost.

It is for that reason that I indicated we would much rather see at the Federal level some broad-based method of revenue-raising that treated not only their needs but many other needs.

There are many different steps and approaches to doing this. What is happening in Cleveland is appropriate. What we have done is quite appropriate. But to be candid, to some extent, we have moved into a marketplace and through direct provider contracting through our own clinics and preferred-provider network of 7,500 doctors and 85 hospitals, and all—we have been able to hold down our health care costs below the trend rate nationally.

The consequence of this is, as long as there are still pressures on doctors and hospitals, and as long as they seek various outcomes in terms of their own income, the costs get pushed on to other people, on to an ever-smaller base of people. That creates all these tremendous inequities that show up in the kind of situation with the small

employer from Texas, who has a fourfold increase in their insurance and can no longer handle it.

The CHAIRMAN. Mr. Kushner, you were talking about the aggressive underwriting that is taking place in the small business market, for small groups. To what extent have these businesses been able to join together in buying insurance, to try to spread that risk? And what are the problems in trying to accomplish it? Do you think that the problems require Federal legislation?

Mr. KUSHNER. Well, the reason that many small businesses cannot join together and put together a program is that there is a network of both Federal and State laws and regulations that prohibit them from doing so, from forming successful multiple-employer welfare arrangements.

One of the problems that small business has is that it lacks the negotiating clout when it goes to the provider community for the rates and, of all the players involved, is playing on the most uneven playing field.

So it is very rare that small employers can ban together to obtain any kind of cost-effective and renewable insurance for their employees.

The CHAIRMAN. Senator Packwood?

Senator PACKWOOD. No questions, Mr. Chairman.

The CHAIRMAN. Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Mr. Peevey, could you describe how you went about developing your extensive PPO network? And in so doing, in developing a PPO network, did your company negotiate set rates—capitation fees, discounts, et cetera—with the various providers? And if so, how, then, would you look upon the development of a national or a regional all-player schedule that might in fact not be as good as what you have negotiated?

Mr. PEEVEY. Well, number one, we did go ahead and set up such a program. As I indicated in the answer to the Chairman's question, we had a situation where our health care costs for our retirees, our active employees, and dependents, alike, were going up, in the latter part of the decade of the eighties, at 23 percent a year, an intolerably high percentage. It leads to the consequences we have heard from others here.

We were able to attract to our health care program a most gifted person, who is sitting on my left, who came up with the notion that we should create our own network, our own preferred-provider organization.

We went out and contracted with the originally 75 but now 85 hospitals and 7,500 physicians, because we are big enough in the marketplace to be able to bring this about, and we have a fee schedule for physicians and typically use per diems for hospitals, that type of thing. And they agree on that, and that is what we pay them.

For the employees and dependents who use our network, we have a 90/10 bemefit. In other words, they pay 10 percent of the cost of visiting a doctor, and 90 percent is paid by the plan, based on the contracted amount.

For those outside of our network it is 70/30, although they have other choices—they can be in HMO's.

We have no problem with the capitation approach, some regular payment that is agreed on and negotiated in advance, and we have that, essentially, through HMO's, too.

We would go for, obviously, as I indicated, an all-payer system that recognized some regional and community differences.

Senator ROCKEFELLER. So long as yours was exempt?

Mr. PEEVEY. Not exempt, but there is no reason that they can't be compatible. And over time we would work toward making it all compatible and not exempt.

Senator ROCKEFELLER. Thank you, sir.

My followup is with Mr. Kushner.

Mr. Peevey talked about the power of his company, that they have the power to be able to negotiate, and that is tremendously important.

Senator Pryor and I have been working extremely hard with small business groups, trying to figure out a way that small businesses would be able to do that.

One of the ways, of course, that you can do that—and I am not trying to push it; I am just trying to explore the idea—is to empower small business by giving those businesses which are uninsured, giving them the right, let us say, to collectively join together to negotiate with providers.

Is this something that sounds attractive?

Mr. KUSHNER. I think, Senator, that perhaps the problem—one of many problems—is that there are a variety of reasons. First of all, of our membership, over 85 percent of our members do in fact provide coverage for their employees. Of those that don't, we hear a number of different reasons why they don't; but the most prevalent is that, one, they cannot find any coverage at all—there is no coverage available to them. And two, when they have had coverage in the past, they have not been able to renew it from year to year if an employee or a dependent of an employee has become ill, that either the new rates that are proposed are so out of sight that they cannot afford it——

Senator ROCKEFELLER. But that is all called "insurance reform." That is somewhat a separate subject. I mean, that can be done through insurance reform—guarantee issue renewability, and all the rest of that. So let us say that was in place.

Mr. KUSHNER. Okay.

Senator ROCKEFELLER. Does the concept of small businesses joining together to empower themselves, so to speak, to be able to negotiate with providers, is that something which is attractive or offensive?

Mr. KUSHNER. No. We would want to look at any of these proposals but, on its surface, it would certainly appear that any proposal that would give small business greater clout in the marketplace, anything that would allow them to better level that playing field—whether it is through the tax code and the differentials there, or whether it is through the ability to band together in some type of multiple-employer arrangement, any relief that we could get for the small employer today—as long as it solves the cost issues, will go a long way towards also solving some of the access concerns.

Senator ROCKEFELLER. Mr. Summers, your testimony is highly compelling, and I thank you for it.

Mr. SUMMERS. Thank you, Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Mr. SUMMERS. Mr. Chairman, if I may?

The CHAIRMAN. Yes, of course.

Mr. SUMMERS. I forgot to ask that my testimony be entered into the record, and there are five other businesses like mine.

The CHAIRMAN. We would be delighted to have it, in its entirety, and we will take it into the record.

Mr. SUMMERS. Thank you.

The CHAIRMAN. I would expect you will probably have some written questions submitted to you, too, in addition to what you have heard.

It has been most helpful. It has been a productive morning. Thank you very much for your attendance.

[Whereupon, at 1:07 p.m., the hearing was concluded.]

HEALTH CARE COSTS AND LACK OF ACCESS TO HEALTH INSURANCE

TUESDAY, APRIL 16, 1991

U.S. Senate,
Committee on Finance,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:02 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Lloyd Bentsen (chairman of the committee) presiding.

Also present: Senators Baucus, Bradley, Rockefeller, Daschle, Breaux, Roth, Chafee, Durenberger, Symms, and Grassley.

OPENING STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM TEXAS, CHAIRMAN, SENATE FINANCE COMMITTEE

The Chairman. This hearing will come to order. Today the Finance Committee continues a series of hearings on the accessibility of affordable health care.

At these hearings, we will hear from people with a variety of views and from all perspectives, whether we are talking about government or the private sector, large and small business, consumers, insurance companies, hospitals, physicians, other health care providers; they are going to talk about the dual problem of accessibility of health insurance, and the affordability of it.

At our first hearing, we had Bob Reischauer, who is the Director of the Congressional Budget Office. He released a report that concluded that the problems of affordable and accessible health care require significant changes in the health care system. Changes that are going to call for sacrifices from all of us.

We have had leaders of large corporations, small businesses, and labor here testifying as to their frustrations with the current system. I think they have offered some very constructive suggestions as to what we should be doing about these difficult issues.

The solution demands cooperation from all affected parties, private and public, and in my opinion, cannot be solved by just one stroke of the legislative pen.

They are tough and complex problems, and they are going to require the best minds we can bring to a solution. And we have one of them here today.

I think we are very fortunate to be hearing from Richard Darman, Director of the Office of Management and Budget. Mr. Darman is uniquely qualified to talk about how health care spending affects the national budget, and the overall economy. I am pleased that he is with us.

43-866 O - 91 - 3

We are also going to hear from a distinguished panel of business leaders representing a cross section of industries, whether we are talking about steel, retail sales, or high technology, who will discuss their experiences in providing health insurance to their employees.

Then we are going to hear from Ms. Rhoda Karpatkin, who is the executive director of the Consumers Union. She is going to discuss how the problems of rising health care costs and lack of universal access to health insurance affects the individual consumer.

And finally, Mr. Dallas Salisbury, the president of the Employee Benefits Research Institute will present an overall perspective of employer-sponsored health insurance benefits.

We are going to have a major attendance here, because of the intense interest by members of this committee, but there is going to be one member missing this morning.

And I want to share my concern and my prayers for a very valued member of this committee who had a heart attack last night; our good friend David Pryor, who is in the hospital here in Washington. I understand he is doing well, but we will all be thinking about him and wishing him well.

I yield to any statement that anyone would like to make.

Senator GRASSLEY. Mr. Chairman?

The CHAIRMAN. Yes.

OPENING STATEMENT OF SENATOR CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. I have just a short observation I want to make. You know, we always thank you for holding these hearings, and I mean to thank you for holding this hearing as well. But it just seems like the more we get into this problem, the less easy it is to see a solution at the end.

So I am not sure I know why you want to take on the responsibilities that you have, but I know that we have to do it, because the public is not satisfied with what we have now, and we have got to try to improve upon it.

But as I listened to the testimony at last week's hearings, and reviewed the materials that my staff provided me for this morning's hearing, I find myself wondering whether we are ready for a major health care reform initiative.

Goodness knows, Mr. Chairman, we are offered on every side compelling accounts of the problems that beset people without health insurance, and that also beset both small and large businesses in their efforts to provide health care insurance for their employees.

The testimony of witnesses who have come before us is compelling, whether it is from those speaking on behalf of those people forced into hardship by major health care problems, or small business people forced to give up their efforts to provide health care for their employees, or even larger businesses under pressures of international competition and facing 20 percent increases in their health care costs annually.

I certainly am convinced that we have a very, very big problem on our hands, and one that deserves our attention. However, I am

also struck by a number of characteristics of the public's attitude about health care.

A big majority of them do not seem to be happy with the overall health care system we have, but at the same time, the same big majority loves their doctors and their hospitals, and they seem satisfied with their health insurance arrangements.

Furthermore, they do not want to pay one penny more for health care. So I must say, Mr. Chairman, speaking strictly as a politician now, we are going to have to be very, very clever to undertake health care reform that does not upset a great many people.

Thank you.

[The prepared statement of Senator Grassley appears in the appendix.]

The CHAIRMAN. Well, Senator, I think I agree with that, but I guess that is what we hired out for. So we will try to work out that solution.

Senator Rockefeller.

OPENING STATEMENT OF SENATOR JOHN D. ROCKEFELLER IV, A U.S SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Thank you, Mr. Chairman. I have to respond to that. It is true, you know, that the average amount that the average business spends per employee on health insurance is $3,200.

It is also true that by the year 2000 at current rates of increase, the average American business is going to be spending $22,000 per employee for health insurance. I suggest to the distinguished Senator from Iowa, that is a crisis that cannot be left for observation.

There are people all over this country who get insurance for peace of mind. And, now they are finding that their insurance may be absolutely worth nothing to them.

People who become ill, are afraid to change jobs—would want to change jobs to get a better job, perhaps, but cannot change jobs because of the fear that they will not be able to get health insurance because the company does not offer it or because pre-existing condition exclusions prevent them from getting coverage anywhere from 6 months to 1 year.

A lot of people think that health insurance—the rather, lack of health insurance, is only a matter of the poor. In fact, 70 percent of the uninsured are not poor.

We are projected—I would say to the Senator from Iowa—to spend $760 billion on health care this year. By the year 2000, there is an argument as to whether the figure that we will pay for health care is $1,800 billion, or $2 trillion. So not doing something about it seems to me not to be an alternative. Mr. Chairman, that was not the opening statement I was going to make, and I will submit that for the record. And I thank the Chairman.

The CHAIRMAN. Thank you. Senator Durenberger.

Senator DURENBERGER. I will pass, Mr. Chairman.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. No statement, Mr. Chairman.

The CHAIRMAN. Senator Baucus.

Senator BAUCUS. I have no statement, Mr. Chairman.

The CHAIRMAN. Dick Darman, we are delighted to have you.

STATEMENT OF HON. RICHARD DARMAN, DIRECTOR, OFFICE OF MANAGEMENT AND BUDGET

Mr. DARMAN. Thank you very much, Mr. Chairman. Mr. Chairman, members of the committee, I thank you for inviting me to testify. And it is always a pleasure, as it is today, to have an opportunity to appear before the distinguished Senate Finance Committee.

I did not know about Senator Pryor's condition, Mr. Chairman, and, of course, he has our best wishes as well. I know I speak for all in the administration.

It is also the first opportunity I have had to appear before the committee since the recent sudden and highly regrettable loss of Senator Heinz. If you would permit me, I would just like to note that, like you, I will long be grateful for Senator Heinz's contributions to the public interest.

Now Mr. Chairman, with your permission, I would turn to the questions you are interested in. And if I could, I will not go through the rather long, and perhaps tedious introductory statement.

The CHAIRMAN. We will include that in the record.

Mr. DARMAN. I would appreciate that.

This is, as you all know better than most, an extraordinarily complex subject. And what I have tried to do is reduce my introductory observations to 10 fairly simple propositions.

I would not wish to have that effort lead anyone to conclude that we believe this to be a simple problem that lends itself to simple solutions. But I did try to, at least, encapsulate the points I would wish to make relatively simply.

I will not repeat all of them, but I would like to touch upon a few points that are made quite dramatically by charts, which are included in the testimony. And I will deal here with only a selection of those charts.

[SEE CHART 1, PAGE 142]

The very first point is that I believe that the problem of health care costs—from a budgetary perspective—needs to be seen as part of a larger problem having to do with the explosion of mandatory programs, generally, as a part of the Federal budget.

And this chart simply demonstrates that graphically. If you look at President Kennedy's day, it is down here at a very low level of mandatory spending, a very small percentage of the budget; less than a quarter.

If you look at where it has gone since, it is almost straight up to where, now, mandatory spending, excluding interest, is in excess of 50 percent of the budget; about 52 percent of the Federal budget, and continuing to rise.

If you look at what has happened to defense over that same time period, this is in 1992 dollars, defense spending has stayed relatively flat within this range. And domestic discretionary programs have risen only slightly, and then leveled off—staying roughly level in '92 dollars over this very long period.

So mandatory programs are exploding, taking over the budget. And health has to be seen in that context, and it is my personal view that even if we could solve the complex problem of health, if it is not addressed at some point in the larger context of the way we budget for mandatory programs as a whole, we are going to continue to have an enormous budgetary problem. Point one.

[SEE CHART 3, PAGE 143]

Now, trying to put health in this framework, this line is total mandatory spending—the same one you saw before. This line is total entitlement spending, which is a large portion of mandatory spending; a very large portion. This big blip upwards you see in here is largely due to deposit insurance. And I would just note as an aside, that what I have termed the hidden liabilities of the government are also themselves, in my opinion, a significant future risk. And I would not be surprised to see this little explosion we see here be replaced by another one. Not deposit insurance, but others, as time goes on. But that is speculative.

Getting back to health—total entitlements. Social Security is what most people think of as the largest portion of entitlements. But health, as you can see from this line here, is catching up with Social Security.

[SEE CHART 5, PAGE 144]

If I could turn quickly to the next chart. This now is switching. The other charts were 1960 up through the present. This chart starts at 1990, and goes out into the 21st century. The red line is health entitlements; Medicare and Medicaid. The dotted blue line on this chart is Social Security. And, as you will see, under current projections, health spending is going to surpass Social Security roughly by the turn of the century—by the year 2000.

So, though health is below the Social Security line on that big entitlements picture that I showed just before this one, it relatively quickly crosses over. And, as you see here, if it continues. . . . I do not believe it is possible—but if it were to continue at the current growth rates, it is just going to dwarf Social Security and become an enormous problem in its own right. This is well-known, and I think not much disputed.

Now, just one final point about the mandatory portion of the budget before leaving this little section. This, again, is taking the health line and looking at Medicare mandatory spending.

[SEE CHART 6, PAGE 144]

This line is Medicaid mandatory spending—same pattern, explosion upward. This is all discretionary spending for health. That is, again, relatively flat.

So it is a way of trying once more to support the general proposition that there is, to some degree, a generic problem with mandatory programs, per se, not just health—that they are really not subject to annual budget review; in some cases, for good reason; and not subject to budgetary discipline.

[SEE CHART 7, PAGE 146]

That said, let me move to a point on which I know you all agree, and that is simply that Federal health outlays are growing rapidly, by almost any measure that you want to look at. If you said as a percent of GNP, the line goes steadily up. If you said as a percent of all Federal outlays, the line goes steadily up.

And this is our own budget here, so you can see it still goes up sharply, moving toward 1996. And as a percent of all outlays, if you said, well, let us put aside Social Security and interest, as some people like to do, what they are doing—the pattern is still the same.

The point I would wish to make here, and I suspect most of you agree with this, is that it is simply not a sustainable trend over the long term.

[SEE CHART 8, PAGE 146]

If you look at what is happening with Medicare Part B as a percent of the budget, this is 1990, moving out in time. Go steadily up, assuming you keep the 25 percent beneficiary contribution, roughly, that is in current law.

That, of course, itself, is a politically contentious issue as the premiums promise to rise. If you do not do that, then the Federal outlays for Medicare Part B are, of course, higher.

If you look at what is happening to Medicare Parts A and B, it is this line up here. And going from well under 10 percent of the budget to levels which are just, in my opinion, prohibitive.

Because they would mean either that the Federal budget itself would be growing to extraordinary percentages of the GNP, which is undesirable economically, or that health would be growing to such a large percentage of the Federal budget, that it would be basically driving out all other opportunities for expenditure.

In fact, to follow this path, you would need—if you kept Federal spending at about 20 percent of GNP, you would need about a 20 percent cut in everything other than health in the budget just to fit health in, on current projections. And I would contend that that is just not realistic. So somewhere, somehow, something is going to have to give.

[SEE CHART 9, PAGE 147]

Let me support the same point by stretching it out just a little bit further on that line that relates to total health expenditures, not just governmental outlays.

Total health expenditures, public and private, Federal and state, for the system as a whole as a percent of GNP. If you look back again at President Kennedy's day, it is down around 5 percent.

If you look at where we are today, it is just around 11 or 12 percent of GNP. If you look at where it is scheduled to go, and there is probably not a whole lot that is going to change this particular projection—it could move a little with policy action—it is scheduled, as this notes, to get to 17.3 percent—this is by HCFA estimates—of GNP by the year 2000.

You then say, well, where is it going from there? I mean, there has got to be some point at which health stops taking over GNP. If

you extend the current pattern—you just continue the current growth rate—by the year 2030 you would have health all the way up to about 37 percent of GNP.

I would contend that that is just implausible. I mean, it is not going to happen no matter what people's policy preference is. So again, the point is, something is going to have to give.

Now, if you ask yourself, suppose we just let health grow in the current system at the regular inflation rate, what we forecast the CPI to do, not with any excess inflation for health.

Suppose we could constrain the growth all the way down to—from the higher level it has been at, down to growth of the CPI. You would still, just because of the aging of the population and other effects, have a growth to above 20 percent of GNP by the first quarter of the next century.

That, bear in mind again, was from a level of 5 percent in President Kennedy's day. It is a peculiar character of GNP when it starts to get to be all health, and obviously, at some point, it cannot be.

[SEE CHART 10, PAGE 147]

Now, turning to the next point, quickly, let us suppose that someone thought you could keep moving in this direction. In terms of the composition of the GNP, and the composition of the Federal budget, as I have suggested, I do not believe that that is possible. But suppose one could over the long term.

You have got to ask yourself how you are going to finance that. So one way of looking at the financing question, I think we all know—you know better than we do, since you run for office, that ordinary individuals are not anxious to assume a larger burden of the financing responsibility.

If we ask indirectly how are they paying, business spending on health premiums—this measures business spending on health premiums as a percent of after tax profits. But actually now, this year, 1990, exceeded 100 percent of after tax profits on health premiums. Again, there is a point at which that, too, becomes absurd.

If you look at it as a percent of total compensation, if you think that a more relevant measure, health has been steadily rising. And there, again, is some point at which you have to say that employees are not going to want to take all of their compensation in health. But the pattern is to take more and more of their compensation in health and health benefits.

[SEE CHART 11, PAGE 148]

If I could run quickly through this next little section. Suppose we were assuming that this would be financed, that the growth of Medicare alone, that is not the whole portion of the problem, but just Medicare—suppose it were to be financed with the equivalent of a tax on payroll. You ask yourself what would these projections—the current projections—translate into taxes as a percentage of payroll? You can see where way down at this very—at this starting point here to finance the gap, and as a percent.

This is the additional portion of OASDI payroll that would be necessary. If you make pessimistic assumptions, Social Security ac-

tuary's assumption set three, you find this rising towards over 15 percent of additional payroll tax—additional tax that would be necessary just to finance the projected Medicare financing deficit.

If you used the intermediate assumptions, you end up in a range that is closer to 5 or 6 percent of OASDI payroll in addition to current taxes, just to finance the Medicare fiscal financing debt. And again, it is another way of saying it probably cannot happen.

I might note parenthetically that for those who are currently talking about cutting the Social Security tax rate in the short term, and turning around and financing it with a tax increase in the long term, as is proposed by some of your colleagues, and not supported by the administration, or as I know, some members of the committee, and you, Mr. Chairman—I enjoyed your letter yesterday—if you imagine a system that switched to current cost financing of Social Security in which, as Senator Moynihan proposes, you would then have to also switch to about an 8.1 percent Social Security tax rate in future years just to finance the current Social Security program, if you add that tax increase which he proposed for the out years to this financing gap in whatever system is going to finance it, I would again contend you have something that is simply not plausible—it is not going to turn out to be feasible.

[SEE CHART 12, PAGE 149]

This is simply a dramatic way to show, in one simple graph, what has been happening to real per capita national health expenditures, heading straight up. If you then ask yourself, as my testimony does, how does this compare with other countries, we are, of course, higher per capita than any other countries.

If you then adjust for our difference in the size of our GDP per capita, we are even more the outliers on the high side. If you then go ask yourself, do we have satisfactory quality and equity in our system to justify this trend, there are many reasons that you could conclude the answer should be no.

[SEE CHART 15, PAGE 152]

Now, let me turn to a point that I think is not as well appreciated as it might be that I think is important to at least have in mind as part of this problem. We have this enormous and growing, and I think, unsustainable Federal health expenditure.

But mentally, I think a lot of people would think well, if the government is in this so much, it must be in there to help poor people. I mean, that must be what is going on, this explosive growth.

Why would government be involved? If you look at what is actually happening with the growth of spending, this red line straight up is governmental spending to the non-poor—people above the poverty line. Now, some of those people are still poor, but they are above the poverty line. If you say how much is going to the poor, it is only this little line down here.

So we have this massive increase, as in the previous chart, in per capita spending. We have the massive increase in governmental spending. And you then ask yourself, but how much is going to non-poor versus poor, you are probably not satisfied with the sense of equity of the system.

[SEE CHART 16, PAGE 152]

Now, this next chart—again, it is in the testimony—is a little bit more detailed on the same point. And it breaks out different components of health expenditure by poor and non-poor.

And this line right in here is the percent of total spending on health, including tax expenditures, received by the non-poor. So this is 100 percent. As you can see, it is bouncing around in the 80 percent range by the non-poor. And this is over time. 1965 to 1995 or 1996.

Medicaid, of course, is intended principally for the poor. And so Medicaid has the best performance in terms of its targeting on the poor. But even Medicaid is not so efficient at targeting on people below the poverty line.

If you look at tax expenditures for employer-provided health plans received by the non-poor, you will see that probably on the order of 97 to 98 or 99 percent of the benefit of the tax expenditures go to the non-poor. That is this line down here—this teeny little line down near zero that goes to the poor. It is just a slightly more detailed version of the previous point.

[SEE CHART 17, PAGE 154]

Now, switching to another, and important part of this equation, this very simple chart tries graphically, dramatically, to show something that I think a fairly large number of people think is one of the many causes of the problem.

And that is that if you look at how much is the individual responsible for in the payment system, and how much a third party is responsible for in the payment system, you have—now this is a different time scale, 1930 to the present—you have an extremely steady increase in third party payment; extremely steady decrease in out of pocket spending for the individual. And essentially, the individual has been almost totally taken out of the equation, and the third party payer has essentially taken over the payment system. A lot of people would say that that creates incentive problems that contribute to the cost escalation.

The reason that I have such a long time period here to look at is that I know, and I would include the administration in this group, that there is good reason to believe, as many do, that the rise of third party payments has contributed to the problem. But before one leaps to the conclusion that it is easily undone, we should at least have in mind that it appears to be a long-term secular trend. There are a whole lot of reasons this is probably happening. It is not as if it happened with one little policy action on a given day.

[SEE CHART 18, PAGE 154]

Now, this chart is too complicated. I apologize. I will try to simplify it in this explanation in the prepared testimony.

We have this enormous growth in national health spending as a whole. And you try to then disaggregate it, and say where is it all coming from, what are the constituent parts? Because you are going to try to get interested in solving the problem. And I will not pause on these breaks by decade, and just look at the whole here.

1960 to 1990. Nominal national health spending has been increasing at an annual rate in excess of 11 percent. If you then say, well, how much of that is from general inflation over the period, it is about 5 percent.

So you then ask the next question. Well, how much is just the growth of the population, 1.1 percent. The remainder is the growth in real per capita spending, and it is almost 5 percent. About 4.77 percent per year, real.

Now, if you then go ask yourself, well, of that, what are the contributing elements? Let me start with the smallest one of the three that is segregated out here.

The relative aging of the population has only contributed about half a percent of that. The remainder is contributed by medical inflation in excess of the CPI, about 1½ percent, and increases in volume and intensity per capita. That is the biggest part—about 2.6 percent.

[SEE CHART 19, PAGE 155]

Let me try to show that point another way—the same point. If you say here is real per capita spending, and what has been going on under that heading to account for the real increase? If you look at in-patient admissions per capita, it goes up just a little bit, and down, but stays about level.

Medical visits per capita move around just a little bit—stay about level. In-patient admissions per capita have actually decreased. Excess inflation has contributed—this is again, 1960 to the present—over the whole period, it is an increase relative to itself of about 50 percent.

But it is this little gap that has to be explained in per capita spending growth, and all these possible contributing elements. The difference here is in the increase in service intensity. That, I think, is the biggest locus.

Now, saying that is the biggest locus of the problem does not yet tell you what the solution is, unfortunately. And it is probably appropriate that I have no charts——

[Laughter.]

Mr. DARMAN [continuing]. For that portion of my introductory comments. But if I could, Mr. Chairman, I would take two more minutes, and then close. In the prepared testimony, I have essentially—I have skipped over some points that I think are important. But I have essentially carried us through page 16 and chart 19.

I would just note quickly, in concluding, that there are a couple of other important complications to this problem which can be simply stated. One of them is on page 17.

It is simple observation No. 8, "That strategies to continue to improve life expectancy are desirable, but they do not necessarily reduce, and they may substantially increase system-wide costs."

The next point is related to that point. Number 9, it says, "If not only average life expectancy which, of course, has been increasing, but also maximum life span, are likely to increase, then budgetary considerations will become an important additional justification for raising the retirement age."

I am not trying to propose this. I am simply noting that we have already got built into these projections an increase in life expectancy, and in life expectancy for people who reach age 65, and for people who reach age 85. And those charts are in the testimony. But the assumptions still tend to assume that there is a natural upper limit to human life span, and, of course, there is a lot of demonstrable, empirical evidence in support of that proposition.

But if you look at what is going on in the large and important investment we make in basic, and health, and bio-medical research, it is at least plausible to suggest that it may be possible one of these days to have a substantial change in the upper limit of life span itself.

That is not in any of these assumptions. If you start to make that kind of assumption, all of these charts start to look even—much more dramatically unattractive. Though, of course, I assume we would all be happy for the extra life, or at least in most cases.

I think that the reason I raised the question with the retirement age is that there is a point at which, if you fail to move the retirement age up as life expectancy beyond retirement rises, the system becomes non-viable economically.

I am not saying we are at that point, but it is not difficult to persuade yourself that we would be approaching that point over the next couple of decades, so one further complication.

My final observation of an introductory nature, and it is the reason I did not have a concluding chart with the solution, is although proposals to increase access and reduce health costs abound, and some partial solutions make some sense, no comprehensive solution yet advanced, in our opinion, is without its share of serious problems.

And I know, Mr. Chairman, you and your colleagues may wish, understandably, to criticize us for defining an important problem and not having the solution. I genuinely believe this an extraordinarily complicated problem, and we are working on coming up with a viable solution, but do not have it yet.

What I have tried to do is display the major competing comprehensive approaches that are now in the public domain and being debated. I know there will be other entrants.

And to first describe them (see attachment 1, to prepared statement), and then offer some summary of descriptive, evaluative comments with respect to each as a means to address the cost problem (see attachment 2), or the access problem (see attachment 3).

As you can see by looking at this summary tabulation, every comprehensive proposal, in our judgment, has, yes, some strengths, but also, some important weaknesses.

And there is such a record of having tried things in the health field with the best of intentions, only to then later suffer from unpredicted or undesirable secondary effects, that I do think it is worth noting the potential problems with each of these.

And before moving forward with any single, comprehensive solution, being relatively well-satisfied that for such a major undertaking the downside risks have been fully thought through.

And that, Mr. Chairman, is—I apologize, a rather long introduction, but it is a complex subject. And I appreciate your allowing me

to present these introductory views, and would be happy to respond to your questions, or those of any member of the committee.

[The prepared statement of Hon. Richard Darman appears in the appendix.]

The CHAIRMAN. Not long at all. And I want to congratulate you on, I think, a very thoughtful presentation——

Mr. DARMAN. Thank you, Mr. Chairman.

The CHAIRMAN [continuing]. Of the relationship of health care costs to the economy, to the budget. I have enjoyed listening to you talk about lengthening of life, and a higher ratio of retired, as compared to wage earners—contributors to the system. One of our witnesses the other day was testifying that people, even with an improvement in health at older ages, are retiring earlier. Is that true?

Mr. DARMAN. I believe that the average age of retirement is actually slightly declining——

The CHAIRMAN. That is what they advised us.

Mr. DARMAN [continuing]. Even though one should—I would have thought that it would be increasing at least marginally. Not as fast as health status, but I would have thought it would have been increasing. But I was surprised, myself, to learn that it is actually decreasing slightly.

The CHAIRMAN. It came as quite a surprise to me, too. Because it further complicates the problem in the years ahead.

I was looking at a report issued by the Steelman Commission, talking about the fact that the rising cost in health care is not unique to Medicare. It affects the whole system.

We listened to Reischauer the other day, as he talked about those things that were done to reform Medicare in the last half of the 1980's that had actually rolled back, or had caused a slower rate of increase in spending on Medicare than national health care spending overall—a modest difference, but an improvement in that direction.

Then we heard testimony from Michael Peevey, the chief executive of southern California Edison, calling for a national spending target for health care, and other Federal initiatives, to try to slow down the increase in the cost of health care.

The AFL–CIO outlined a comparable proposal, and I think later this morning we are going to hear from some other businessmen who are talking in that direction. Do you agree with that, or do you not believe that health spending is something that reaches beyond Medicare, and that therefore, calls for a broader solution? Do you still think a portion of that solution should be further cuts in Medicare and Medicaid?

Mr. DARMAN. Well, Mr. Chairman, we do stand by our budgetary proposals for additional, rather limited, restraint. Though, as you know, those proposals have not been enthusiastically received by the Congress.

The CHAIRMAN. Or the Chairman.

Mr. DARMAN. Or the Chairman. And I know you are not alone. On the several points you made in your question, if I could make a few quick points.

I believe you are correct that there has been some improvement in hospital costs, and there has been some improvement in physi-

cians' costs. The hospital cost improvement came earlier. The physicians' cost improvement—no. I am not sure of that.

In any case, it is correct that the restraint on prices, or reimbursement, has had favorable effect. Here are the problems, however.

There is the question, what is the natural limit of that?

How much of it is a one time favorable effect, just squeezing some things out of the system that can at no loss be squeezed out once, and how much could you expect to continue?

In other words, do you just ratchet the system down a little bit, but then return to the higher growth rates? We have not had enough experience over time to know the answer to that question yet.

A second question is what does it take to beat the system? When you have a price regulated system, and just price regulated, inventive participants can almost always find a way, and have found ways, to increase utilization in order to keep incomes up.

And so the question is, what are the secondary effects as people learn to game the system? Now, that then leads, I believe, logically by some way of thinking, to the last part of your question.

Well, if you are just clamping down on a piece of the system, and people can game it, maybe logic would say the solution is to put an overall cap on the whole somehow. The problem with that, I believe, is that it can, and at some point it must, lead to rationing of some sort or another. That is, rationing by a means other than price.

Now, that opens up a whole host of possible problems. And you are well-familiar with the arguments about that. I think a distinction can be made between what the Federal Government should do with respect to those areas in which it is the insurer, and what needs to be done for the system as a whole.

Yes, there has to be a solution for the system as a whole. My own personal bias would be to try to move more towards competitive pressures as a restraint on price, rather than an aggregate cap on the total amount that could be spent.

But again, that, too, as the detail in the back-up of the testimony suggests, that, too, has problems.

The CHAIRMAN. You have successfully filibustered my time. [Laughter.]

Mr. DARMAN. I am sorry.

The CHAIRMAN. No. No. I think that is a good comment. I understand it. Obviously, I have other questions, but in following our early bird rule here, I call on Senator Durenberger for any comments, requests.

Senator DURENBERGER. All right. Thank you, Mr. Chairman. I think it is appropriate to begin by complimenting you for this series of hearings, and the context in which it is set. I see Mrs. Bentsen is here this morning. I am going to compliment you on the breadth of your interest, and the depth of your interest in the subject, as well.

And then a special compliment to Dick Darman, and to Tom, and the two Steves and everybody else that had a role in putting "the problem of rising health costs report" together, because I think it

is a very, very significant contribution to try to put what we deal with here in a much larger perspective.

I have trouble with the characterization "simple observations," but I know it is characteristic of the Director to put these in that kind of context, because they really are. None of these observations are that complicated.

The question I think I would like to ask you, Dick, because we have only this relatively short period of time, is to help us deal principally with the part of the system that is uniquely American.

And as you illustrated with the X-shaped chart on contributions to the system, we have taken a system in this country, which used to be consumers and providers of health care, and we have injected over the last 30 some years a major role for third party payors.

The government, to some extent; the employer to some extent; and then this phenomenal intermediary called an insurance company that we in government use, and the people in the private sector use to pay these bills.

And for all of us who have engaged in the Pepper Commission, and these other efforts of some kind of comprehensive reform, the thing that continues to evade us is the most appropriate role of the third party, or the intermediary.

With all due respect to the people who advocate the so-called pay or play system, at least they are willing to recognize that culturally the third party in America plays an important role.

And while I might disagree with my friend from West Virginia about the appropriateness of employer mandates, he at least is recognizing that if you are going to change the system, you ought to use something that is culturally American.

That is, a third party, an employer who, as part of the arrangement with employees, is willing to make a contribution.

So as we look at getting our hands around this system, the frustration is that these third parties keep increasing the dollar amount of their contribution, just as we do here in Medicare and Medicaid, but there is no theme, if you will, or no stream of consciousness, except from some of the witnesses we are going to hear from here today in the business sector to the role that they play in appropriate and necessary use of this system.

We still have first dollar coverage in this country. We still have freedom of choice all over.

We still have people resisting the notion that the tax subsidy ought to be used to reward those who have the capacity to put lots of money into this system, and to penalize people who do not have the capacity to put that into the system.

So what a lot of us struggle with here is should we keep this third party in the system, or not? Should we keep the employer in there, when there are millions of them? Some of them are big. Some of them are small. Some of them are multi-national. Some of them just sell shoes in the local market.

What about this thing called health insurance? I mean, it is not insurance anymore. There is an insurance component to it, but it is a bill paying service. So what do you do about that?

So, if you are thinking about an eventual comprehensive solution, maybe it would help us to get some instinct from you about the role that you think, in this whole comprehensive approach to

reform, the role that these third parties should be playing, and what we need to do to help them play a better role in curbing the costs, and improving the access.

Mr. DARMAN. Well, thank you, Senator Durenberger. I think you made, obviously, several good points. One important one is my suspicion would be what I gather yours is, that there is a fairly powerful cultural bias in favor of a third party payment system in the United States.

And that was why I tried to show that the phenomenon has been building steadily since the 1930's, and looks somewhat like a secular trend.

I suspect that insurance—I suspect we are going to want—all of us from different perspectives, are going to want to keep insurance companies in the system.

I suspect—if you look at the varying plans, in fact, they all do—not all, but the Enthoven option, several variations of the pay or play options, and the AEI and Heritage options all envision a continued role—a very major role for insurance systems. And in differing ways, imagine structuring incentives to force competition among plans.

And I think we have got to get down to a more specific level of inquiry, and I know you have done this more than I.

Exactly what behavioral responses do we expect from—and what empirical evidence is there to support the expectation for each of these different proposed incentive systems—empirical responses of a favorable variety to increase the discipline that would come through the role of intermediaries; plan organizers, plan managers. That is one question.

And then what are the adverse side effects associated with each of these that we would expect behaviorally, and what do we propose to do about that, that is not going to end up complicating life impossibly, or making the problem worse if you try to fix it over here.

It is when you get into the detail of these that I think, unfortunately, the problem consistently turns out to be hard. And I do not have a solution at the moment.

Senator DURENBERGER. Thank you, Dick.

The CHAIRMAN. Thank you. Let me remind the members of the procedure the Chair uses to call on the members. That is, for those who arrive before the time the hearing starts, we use seniority in calling on them.

For those who arrive after the hearing starts, we take them in the order of arrival. Now the reason I had to finally do that is that I had a member or two who started arriving 30 and 45 minutes before a hearing would start, and I did not want to see members camping out outside in order to be first. [Laughter.]

The CHAIRMAN. So with that in mind, I now call on Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman. And thank you, Mr. Darman. I thought that was just a superb presentation.

The figure, whatever it is—37 percent of Gross National Product being eaten up by health care by the year 2030, tends to get the attention, as does the average cost to an employer for health insurance of $22,000 by the year 2000. We understand that not all of

that 37 percent or 12 percent, or whatever it might be now, is government spending. It is both public and private health spending.

I want you to be philosophical for a moment. If you look at those figures on your chart, you sort of come to the conclusion—and it seems to me, in a sense, that you did almost by tone of your voice, that these figures are so bad, they are impossible to comprehend. In fact, if you look at costs per capita in Japan, and Canada, and other places that have national health insurance, their costs per capita has gone up as fast, or in the case of Japan, much faster than ours over the last 5 to 10 years, or so. And ours is a so-called free market system.

The tendency is to say this is out of control. It is so big, you have got to do something about it. But then what can we do? You say, well, the American people are not paying enough of the cost of it.

I think that those of us—Senator Durenberger and I—who served on the Pepper Commission, would agree that people have to share in the costs of their care. I think health care is the pocketbook issue.

I think people—families are afraid, small businesses are afraid, big businesses are, government—we are all afraid of the cost of health care. It is out of control.

My question is at what point, as the figures continue to rise, does it become substantively, as well as philosophically, correct to say we have to intervene in some way, even a small way. Knowing that it will not solve the entire problem. Take for example, prevention.

For example, WIC. WIC lowers Medicaid costs, which you referred to in your chart, substantially. In fact, every dollar of WIC spent—pregnant women expenditures, saves between approximately $2 and $3.

That is an enormous saving when you consider that over 433,000 women at this moment do not have health insurance. Many of them will not get pre-natal care and could probably benefit from WIC assistance.

Or, for example, take pre-natal care. Every dollar you spend for prenatal care saves $3.38 not just for intensive care, but in re-hospitalizations, and all of the other problems that occur later on for a person who is cognitively or physically impaired.

So the philosophical question is even as health care costs grow out of control, is it not important that we try to save money for the future.

What it would save you, I think, is unmeasurable in terms of future outlays. Philosophically address the escalating costs versus the responsibility of the government to expand its efforts in prevention, please.

Mr. DARMAN. Thank you, Senator Rockefeller. A few quick comments. Yes, I agree that we should do those things that we have some confidence in the short-term, such as investment more in WIC, and other preventive measures. And we have proposed some of that in our budget.

I also believe that we can continue to do some more with cost control with respect to physicians. But I do not believe these come close to addressing the problem, and I do agree we should take these steps. But I do not think we should fool ourselves into believing that they are going to solve that 21st century problem.

Indeed, if you look at something like prevention, prevention can actually make the cost problem worse, depending on how it is managed, and how it is targeted.

I note in my testimony, and I want to make clear I am not—well, let me first state, take the example of infant mortality. We have proposed a targeting system to try to put resources into the infant mortality problem, and reduce infant mortality in this country.

It is principally targeted on very poor people. If we are successful, and that is all we do, we could actually end up increasing the system costs. Because the subsequent life chances of many of those people are, at least statistically, troublesome. So the corollary of that is not do not do it.

I see you shaking your head. The corollary is if you are going to invest in prevention, or in things which extend life, and we should wish to do so, we have to also make investments in policies that are complimentary to increase the chances of the people who are so helped, also being able to become productive. So that over the long-term, on average, they collectively pay for themselves.

I know time has run out, but a couple of quick additional points. Yes, cost sharing would help, and I tilt toward it in here in some measure.

But again, it is not going to be a panacea, because there is a fair amount of evidence to suggest that yes, it helps at certain levels, and we are for increased cost sharing. And I know you, and others are.

But once—at least as I understand the evidence from the Rand study, increased cost sharing affects the tendency to visit doctors.

But once in the care of doctors, utilization does not change much with one kind of cost sharing system, or another. The control tends to shift to the managers in the health care system, and away from the consumer.

So there has to be something else. You said be philosophical. I think in the end—and this is what is so hard about this problem, in the end, logic is going to—we live in a hybrid system at the moment.

And logic is going to tend to drive people either towards a more comprehensive—fully comprehensive regulatory system that ultimately involves problems of rationing, or a system that relies much more on competitive measures as the cost restraints and resource allocators.

And the problem I believe we have as a political system is you can make a case that each of those alternatives is intellectually defensible. A respectable case can be made for each one.

The probably least defensible case is the one in the middle, where we are. And I do not see our political system having anything remotely like consensus for heading in either the one direction, or the other.

I do not believe our political system wants to move towards comprehensive rationing, or eliminating a good portion of the private intermediaries, or private providers.

But I also do not think, even though my prejudice would be in this direction, that the political system is ready to move towards a fully competitive system. That is our dilemma, as a practical matter.

The CHAIRMAN. Thank you.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. Yes. Based on your last statement then, does that mean that the administration will not have a comprehensive reform proposal and that, because of the politics of it, we should just proceed in a careful, piecemeal way?

Mr. DARMAN. No. I would say that we do intend to have a comprehensive proposal. We are treating it very seriously, and it is an extremely hard problem, as your introductory comments themselves, suggested, Senator Grassley, to find a comprehensive solution in which you have enough confidence to move forward. But Secretary Sullivan is leading the administration's effort to try to develop such a solution.

We badly need one, as my introductory comments suggested, but I do think that the "first, do no harm" principle should apply when it comes to comprehensive reform.

If you are going to have a fairly substantial shake up of the system, I do believe we all have some obligation to have a high degree of confidence that, based on what we know, we think it will work. And we are not there yet.

Senator GRASSLEY. We have the Steelman group already referred to, and you just referred to the one, I assume, that Constance Horner is heading up for HHS.

Are you in a position to tell us what direction those studies might take, and/or when there might be a report ready?

Mr. DARMAN. I am not. I know that Secretary Sullivan has said that he intends to make sure that his group does benefit from the Steelman Commission's work, and reviews it.

And I understand, and I believe it is sound, that he has also said he wants to review the National Governors' Association Task Force work on this before coming forward with his own, and his interagency group's recommendations within the administration.

If I could just add one word. This last point is not insignificant in my mind, the National Governors' interest.

We included in our budget for the first time a section called "States as Laboratories," which tried to take a look at different experiments going on in different states under the heading Access Reform and Cost Control.

And there is a substantial degree of variation among the States. I believe it is prudent for us to try to learn as much as we can from the State experience with the bolder efforts. And some States, of course, as you know, are talking about making even more radical changes.

And if you can—at least in my opinion, one of the great virtues of the Federal system is if you are going to make radical changes, you have a chance to see what they look like in the small, before you do it for the system as a whole.

And it is only prudent to do so. So we have some interesting experiments going on in the States. I wish we had more of the competitive model variety going on in the States. Unfortunately, there are more heading in the comprehensive regulatory direction.

Senator GRASSLEY. Well, would you expect that there would be a recommendation ready within the next 18 months?

Mr. DARMAN. I would very much hope so.

Senator GRASSLEY. Okay. Is the administration thinking about offering a proposal separate dealing with medical malpractice law reform?

Mr. DARMAN. Yes.

Senator GRASSLEY. I have heard that they have been.

Mr. DARMAN. Yes.

Senator GRASSLEY. Would those recommendations be coming sooner?

Mr. DARMAN. Yes. In fact, we included—I referred to it, or it was referred to in the President's budget, in that part of what we have in mind involves creating a pool of financial resources to be incentives to States to adopt specified malpractice reforms.

The States that would adopt the reforms would get a little extra in Medicare and Medicaid. The States that would not would get a little less. And what has held up the public announcement of this is exactly what the requirements should be to qualify for particular States.

And the Attorney General, and the Secretary of HHS have been sorting that through with our Domestic Policy Council. But I would hope we would have those details announced within the next few weeks.

Senator GRASSLEY. I would like to have you address cost shifting. Not only because actual costs are shifted when the Federal Government does not pay a full share to providers, or to insurance people, but also to cover some uncompensated care.

One of our later witnesses today will say that cost shifting may be the most important factor in the destabilization of our health care system.

To what extent do you believe that public programs such as Medicare, and especially Medicaid, contribute to this problem of cost shifting by not paying providers what it costs them to provide care to the beneficiary of these programs?

Mr. DARMAN. I cannot give you a quantitative answer to that. It is my personal judgment that in aggregate, they ought not to contribute to such cost shifting.

There is cost shifting within the private system, in that the insurance system as a whole—private and private premiums, it has been estimated—I do not know how reliable this is—it has been estimated that there is about a 7 percent subsidy of uncompensated care in regular paid for insurance premiums. I do not know if that number is right.

Let us say it is 5 to 10 percent. There are ways in which I think the Federal Government does tend to subsidize uncompensated care. But if you mean drive the costs elsewhere, I do not think our reimbursement system does that.

Senator GRASSLEY. I am done, Mr. Chairman. I just observe, though, that I think it is not realistic to think that there is not some cost shifting because of what Medicare and Medicaid does.

Mr. DARMAN. I think there is cost shifting, Senator; a very large amount of cost shifting in the system. But I am only questioning the direction with respect to those two programs.

The CHAIRMAN. Thank you very much. Senator Breaux?

Senator BREAUX. Thank you, Dick, for your testimony, and for the charts. I think the charts really indicate to me that it is not a question of if we are headed for a big train wreck; it is just a question of when it is going to occur.

And one of the most dramatic charts, from my perspective, that you showed us, was the one illustrating that the out-of-pocket share of the individual's contribution to the health payments in this country is dramatically going down, and third party payments are dramatically increasing.

There has been some suggestion that if we somehow had consumers paying more, that perhaps that would be some way of putting the brakes on the increase and the cost.

I think that an individual, when they go to receive medical services, is really not concerned about the cost at all. It seems they want good treatment, they want it quickly, they want it to be done successfully.

And then we all worry about the price and the cost after the procedures are complete, and hopefully the patient has been restored to health.

I guess my question is is it your recommendation, or OMB's recommendation that somehow we should increase the consumer's portion of the payments as a means of putting the brakes on the cost?

Mr. DARMAN. Senator, I am not here to make specific recommendations at this point, though I do look forward to being able to come back at some point with Secretary Sullivan with recommendations.

But if I could just make these comments, though, with respect to your question. I think you need to distinguish at least a couple of ways in which the consumer could have a larger role in providing some degree of discipline.

One is with larger co-insurance and deductibles. And I referred to the Rand study and what it tends to show about the pluses and minuses of that.

But I think on balance, the answer is yes, there ought to be somewhat more consumer participation there. But the returns are going to be limited for the reason you alluded to, and the reason I alluded to before in referring to the Rand study.

The second way, though, that a consumer can be involved more, is in plan selection itself. And making judgments about what kind of plan to purchase for a given premium level, or how high a premium level to pay and trade for what kind of expected return.

Senator BREAUX. On that point, Dick, I, as a member of Congress, probably have several options to choose from. But the average employee comes in and he or she gets the health insurance plan that his or her employer has already decided is going to be the only one available to all of his employees.

I mean, would that not be how it works? The employee does not have a choice, in other words. He or she just gets whatever the job provides for him.

Mr. DARMAN. Right. But some of the more radical reform proposals that move more towards a bigger consumer role as a part of an improved competitive discipline, such as the AEI proposal that I have alluded to and outlined in this testimony, they would essen-

tially reduce dramatically the role of the employer in the selection process, and increase dramatically the role of the individual in choosing among what is at least hypothesized to be a new set of interesting options, directly marketed to individuals by large insurance companies and provider groups.

Senator BREAUX. While the individual's out of pocket payments have been going down, the chart points out how much employers, or third parties' payments have been going up. And I note that in 1965, businesses were paying for about 17 percent. Now it is 28.8 percent.

Is that a possible role, that if the consumer cannot make the difficult choice, that perhaps it is going to be incumbent upon the business who is providing that insurance coverage to make the decision on how much their employees can afford?

Mr. DARMAN. Well, some number of years ago the answer to that question was yes, in conventional wisdom. And I think people would say that businesses, in some cases, have made significant advances in trying themselves to act as competitive disciplinarians in the system, on behalf of both the employees and themselves, since they are picking up a portion of the tab.

But the restraint that some people thought would come from that, in my opinion, has not yet materialized to the degree that one would need in order to say you should rely on that to deal with what you refer to as the coming train wreck.

For a variety of reasons, business does not seem to have had enough power in the marketplace, or in labor management negotiations, whichever side of the equation you think should give, to slow the growth of the costs significantly.

Senator BREAUX. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman. Mr. Darman, first, I also want to acknowledge the presence of Mrs. Bentsen in the audience. It is good to have you here, Mrs. Bentsen.

I would just like to explore with you, Dick, the degree to which, in your view, this country has to begin to ration health care. We already ration, as you well know. There is a rationing system which leaves out many poor people and people who work in many small businesses.

What it comes down to, it seems to me, is there is no free lunch. Everything has limits. This country just has to do a better job rationing our health care. We have to have a more rational system of allocating our medical care.

And if that is the case, it seems to me that we must begin with universal coverage. We must be more comprehensive than has been the case in the past.

The health care problems in this country basically came about because we have a health care free-for-all. Each provider is out for himself, each insurance company is out for itself, each intermediary is out for itself, each person is.

As a consequence, there are some major winners, and some major losers. But when it comes to health care, I think most Americans do not feel there should be winners and losers.

This is not a business; it is health care. I think most Americans think that essentially every person should basically be entitled to

reasonable health care. Not perfect health care, not all of the intensity that you alluded to in your charts, but good basic health care.

I know that has been the concern in my State of Montana. The State Legislature, in this session, recently passed a resolution calling on Congress to pass a Canadian-like system, and it was not partisan. It passed by a wide margin in both houses in the Montana Legislature.

Now, maybe that is in part because we are close to Canada. We probably talk more to Canadians in Montana than do people in other States. But at least the majority of Montanans, as reflected by the Legislature, believe that some kind of a Canadian system makes sense.

So I would just like to establish the principle that we have to come up with a more comprehensive, a more rational system of rationing health care. We spend more than any other country as a percentage of our GNP on national security. We spend more on health than any other country.

Those trends obviously can not continue as much as indicated in your charts, at least on health care.

So do you not think that what this comes down to is establishing the principle that there is no free lunch, we need limits—that everybody cannot have Cadillac health care; that everybody should have at least Chevrolet, or Ford, or Chrysler health care?

And that we need a system where this country comes together and some people do not profit a lot more at the expense of those who do not get health care?

Mr. DARMAN. Thank you, Senator Baucus. Let me make four points. First, I think you need to distinguish the—what I would call the equity, or the access issue from the cost issue. They are related, but I think they could be separated.

And in looking at the question of equity, fairness, access, yes, there are inequities in the current system. Some of them will always be with us, but some are clearly undesirable, and ought to be remedied. For those, there will be some increased cost to the system as a whole.

And for that, the question is, having decided at some point that one wants to make the system more equitable in terms of access, who pays? How do you distribute the burden of that increased cost, because there will be increased cost.

That, I think, is a separate question. One could be concerned about fairness, but then you have to answer the financing question. A separate question from what kind of system is the best system to restrain the growth of costs?

Assume you had an equitable system in terms of who is eligible. What kind of system is the best system over time to restrain the growth of cost? A more market-oriented and competitive system, or system that has more formal rationing, governmentally-managed rationing.

Senator BAUCUS. I might just quickly interject, briefly. There are some problems with market-oriented——

Mr. DARMAN. Yes.

Senator BAUCUS.—in the sense that hospitals compete and drive up costs.

Mr. DARMAN. Yes, absolutely. I plead totally guilty to saying there are problems with all of these approaches. That is our dilemma collectively, I believe. And it is a genuinely hard problem. A genuinely, extremely difficult problem.

Two quick final points—red light. Canadian system, I said a few good things about it in passing in the testimony here. It is noteworthy also that there are some things to be said on the other side; that if you make demographic and cultural adjustments, you could say that life expectancy is lower, not higher.

That for high risk surgery, their record is not as good as ours in terms of efficiency. It is better for moderate and lower risk. Again, it is complicated.

Final point. When you think in terms of comprehensive rationing, if you imagine that chart where health grows to 20 percent of GNP—not all the way up to 38, but just age it at the inflation rate.

And you say 20 percent of GNP. If we have price and supply rationing for 20 percent of GNP, we have got a rather different economy than we think we have at the moment, and than I think most of us would prefer to have. That is a very big step to imagine a move towards formal, aggregate supply and price regulation for 20 percent of the GNP.

The CHAIRMAN. Thank you. Senator Daschle.

Senator DASCHLE. Mr. Chairman, I, like the others, have enjoyed the presentation. I think it is one of the best chart presentations on the issue that I have seen. Like the others, I am equally disappointed that there was not a chart with a solution.

And I cannot help but think lack of consensus is not a good enough reason why the administration would not propose a solution.

I can personally attest to the fact that there was not much consensus on the Persian Gulf, yet the President showed some real leadership in spite of that lack of consensus, and he addressed that issue with leadership, the likes of which is all too rare in this town.

I would like to see that same kind of leadership on this issue. You make some statements, also, with regard to our alternatives, that in my view, are provided as fact, but I think are more proposition or supposition.

I do not think it is fact that if we provided universal access with certain kinds of systems we would see increased cost. In fact, the experience of other countries shows that costs have gone down in terms of the total amount of GNP devoted to health care, in terms of per capita increases, whatever criteria one uses.

The other issue I think we really have to be careful about as we throw terms around is this notion of rationing. Rationing could easily become the word that destroys whatever opportunities there might be to consider comprehensive systems.

I think there is a difference between allocating on the basis of need, and rationing on the basis of the ability to pay. I—and again, this is not fact, and I will lay that out.

My view is that we now ration on the basis of the ability to pay, while other countries may allocate on the basis of how doctors and other providers see the need.

And it seems to me that we have to be sure that as we consider these options, that the terminology does not, in some way, prejudice that discussion.

Finally, I do not know how anyone could conclude after those charts that we can do anything other than consider a comprehensive system. Frankly, I do not see how you can tinker—how you can nibble around the edges, when you have laid out the facts as persuasively as you have. And that leads me to my first question, and maybe my only question.

My first question is, as you look at other countries—every other industrialized country, it seems to me they have all concluded that the only way to deal with this issue in a comprehensive way is to consider, and ultimately adopt, a globalized budget on an annual basis.

Other countries believe this is the only way to control costs—by defining a globalized budget, they decide how much they are going to pay.

Now, my question is this. Is that statement true, and secondly, are there alternatives to comprehensively control costs, other than a globalized budget, as has been adopted in other countries?

Mr. DARMAN. Yes. There are analytically available alternatives, Senator. It is somewhat definitional.

I think all of the options that I have arrayed in the Appendix—see attachments—here would portend to be essentially universal, or near universal in their coverage, and in that sense, comprehensive. But some are very much more market-oriented, and others apply global limits. It is possible to be comprehensive in coverage without being—without having global limits. If I could just correct the record on one small point.

Senator DASCHLE. Before you do that, I think it is important to point out that you cannot address access without addressing cost. So you can come up with a hundred separate ways——

Mr. DARMAN. I tried to separate them. I tried to separate them.

Senator DASCHLE. I know you did, but what I am saying is, there is no effective way of controlling costs, and providing universal access, other than a globalized budget, if you assume that other countries have examined the same problems that we have examined.

Mr. DARMAN. If we always followed the European model, we would have an extraordinarily different looking economy; not just in health, but in a whole range of areas.

And so I do not believe that we should, in all cases—I do not think we should ignore other experience. I refer to it. But I do not believe that we should be bound by it, either. But could I clarify the one point I wanted to clarify?

Senator DASCHLE. If you could just clarify, in the short time that I have, whatever you are going to clarify, but also, give me the alternative to a globalized budget that could be used to control costs.

Mr. DARMAN. The Enthoren system, the AEI system, the Heritage system.

Senator DASCHLE. They do not control costs.

Mr. DARMAN. They argue that they do control costs. I do not say that it is demonstrated. I am not proposing right here a solution.

What I am saying to you is analytically we have a lot of pretenders to solutions, and there are pluses and minuses with every one of them.

And you will find—and I guarantee that the authors of these plans will not be pleased with some of our comments. We are critical of some of the elements of those proposed solutions, but also of the global budget solutions.

And again, I would suggest, why not at least look more carefully at some of our own State experience before we leap to a national solution here?

Could I clarify one point? I really was not trying to say that the reason why I do not come with a solution here is that there is a lack of consensus. That is a separate matter. That is a hard problem in its own right. The reason is, at least for myself, I do not yet have intellectual confidence in the quality of any one comprehensive solution. We are trying to get from here to there.

When we have one, we will wish to come forward and try to persuade the political system to move in that direction. But the reason really is much more related to the analysis of the merits and the evidence in support, and against these various pretenders to comprehensive solutions. That is the reason.

Senator DASCHLE. Thank you.

The CHAIRMAN. Thank you very much.

Senator Chafee.

OPENING STATEMENT OF HON. JOHN H. CHAFEE, A U.S. SENATOR FROM RHODE ISLAND

Senator CHAFEE. Thank you, Mr. Chairman. I would just like to make a couple of points, and have a couple of questions for you, Mr. Darman. First of all, I think it is important to note, as you have, that the current system if we call it a system—is not working very well.

In 1981, the Center for Disease Control said that measles would be eliminated by the middle of the 1980's. Instead, it has not been eliminated, due to lack of proper immunization, and a series of other factors. In 1989, there were 27,000 cases of measles in our country, and 60 deaths. So we are not moving forward, we are going backwards in many instances.

Now, it seems to me that there are plenty of improvements we can make in the existing system.

For employers 100 percent of the cost of providing health insurance coverage to employees is deductible as a business expense under the Tax Code. The benefit that the employee receives, not matter how generous, is non-taxable to the employee. If that same employee works for an employer that does not provide health insurance, first of all, he has to look around for an insurance policy.

First, that policy will be more expensive than a group policy. And secondly, when the employer goes out and buys a policy he pays for it with after tax dollars. This is terribly unfair in my judgment.

Now, in the past, the administration has asked for a cap on the employer deductibility of health insurance policies; whether it is $1,200 a year for a single employee, or $3,000—is for a family.

Do you believe that those type of programs hold down costs, limitations on what the employer can deduct; a cap?

Mr. DARMAN. I believe that there is good reason to think that they might, yes. And several of the major plans would propose to use that as an incentive to get individuals to be more cost-conscious in choosing plans.

And the theory is that the competition among would-be providers of plans would result in greater efficiency in the system. I think, in theory, it strikes me as sound.

Senator CHAFEE. What about carrying it a step further and saying the only deductible plans are those that would provide for a co-payment, 20 percent, if you want. Do you think those would hold down utilization?

Mr. DARMAN. From what I understand of the empirical evidence, and I do not pretend to be an expert on this, the effective significant change in behavior tends to be closer to 25 percent co-insurance. That is what I was led to understand. I am not sure that that is what the empirical evidence supports, but that is what I was led to understand.

And at that point, you do have a question as to whether consumers would, in fact, be pleased with such a system—both as market actors, and as political actors.

But in principle—and I gather also in practice—at some level, there is a significant improvement in one part of the behavior; the individual's decision to actually visit a doctor.

As I said earlier, there is a related problem, I gather though, that once the individual decides to enter the system, essentially decision-making is turned over to the doctors and providers.

Senator CHAFEE. Who might just increase the volume.

Mr. DARMAN. Might.

Senator CHAFEE. In your presentation, you talked about the income-related Part B premium under Medicare. In the President's fiscal year 1991 budget proposal all the savings from the proposed increase would go into deficit reduction. And in your statement you said some of the savings could be used for other purposes, including expanded health benefits for the poor, or the uninsured poor.

Now, AARP has testified here today, and endorsed the concept of an income-related Part B premium in the context of overall health care reform. Not just by itself, but in the broader context.

It seems to me that you have a far better chance of selling this proposal if you have all the savings under the income-related Part B premium going into helping the poor.

Maybe lowering the premium for very low income individuals in conjunction with an increase for the wealthy would be more feasible. I think you have got a better selling case in that situation.

Mr. DARMAN. Yes, Senator. I agree that you have a better case, and I would say further that—and what I tried, perhaps not very artfully, to suggest by the mention of this in the testimony, is that ultimately it would be my expectation that our political system will be driven to reduce subsidies for upper income people in order to finance the increased access for lower income people.

I think that that will eventually happen, because we are going to be in need of the resources on the public end, and the logical place in our system will be through decreased subsidy on the upper end.

The point I was trying to make, though, in the testimony, is that that addresses an equity problem. It does not actually reduce costs to the system as a whole. It can increase costs for a system as a whole.

One of the reasons that we did not propose that in the budget ourselves is that I think it should be linked with the comprehensive reform proposal, and does not really make a whole lot of sense freestanding. And since we do not yet have a comprehensive proposal, we do not have the missing ingredients.

Senator CHAFEE. Okay. Thank you.

[The prepared statement of Senator Chafee appears in the appendix.]

The CHAIRMAN. Thank you, Senator Chafee.

Senator Bradley.

Senator BRADLEY. Thank you very much, Mr. Chairman. Mr. Darman, first let me say that I think that your testimony and this document is really well done.

Mr. DARMAN. Thank you, Senator.

Senator BRADLEY. I think it is clear. You have laid out the problem. I missed some of the early questions, but if was going to ask you, what are we going to do about these costs, and you were forced to answer in just a few sentences, what would you say? There are people out there who are hurting because of higher health care costs.

I can go into a lot of stories about individuals who were crushed by the costs of health care, and a lot of other families that are destroyed by the prospect of those costs.

You have laid out the problem brilliantly, clearly. Now the question is what do you suggest we do?

Mr. DARMAN. Well, I have said, Senator Bradley, that we do intend to come forward with a solution. I recognize the need, and the obligation to do so, and it is a fair point that you make. I made it preemptively.

I did not expect that to get rid of our practical problem. We have got a big problem, as you suggest, clearly defined without yet a fully satisfactory solution.

If you were to ask my personal bias at this stage, I am not really sure what value there would be in providing it. I think, as a member of the administration, I have an obligation to wait until we, as an administration, have an agreement and a recommendation to make.

I have said earlier that we would hope to be able to do that after seeing the Steelman Commission work, and the National Governor's Association work. But we are not trying to run away from this problem. We want to have a solution, and a respectable one, and one we could be proud to defend, and fairly confident would work.

Senator BRADLEY. But do you have a time by which you will have such a proposal?

Mr. DARMAN. I was asked, I think perhaps, by Senator Grassley if I thought it would be within 18 months. I said I certainly hoped so. We had originally hoped to have it by the end of last year, and it has been delayed and delayed. But I think—I really do believe—

genuinely believe that these are extremely hard problems analytically.

And if you are talking about comprehensive reform, and not talking about tinkering, I think you have an obligation to have a high degree of confidence in what you are going to propose. And we are not quite there yet.

Senator BRADLEY. On the Medicare trust fund—the hospital trust fund, right now it is scheduled, given present rates and cost to run out of money around 2000?

Mr. DARMAN. Right.

Senator BRADLEY. What are your thoughts—what do we need to do about that?

Mr. DARMAN. Well, we have got a big financing problem, there is no doubt about it.

Senator BRADLEY. So that as it is now, by 2000, given present rates of tax and present benefit levels, the hospital insurance fund will run out of money.

Mr. DARMAN. That is correct. And if you look at the combination of the Social Security obligations and the health insurance obligations in the trust funds from 2000 on—and it gets worse with time for health, and eventually gets substantially worse for Social Security—I do not believe you can reasonably reach the conclusion that you ought, at this point, be cutting the payroll tax.

Senator BRADLEY. But what do you do about the year 2000? Assuming you do not cut the payroll tax, maybe that will be done, maybe it will not be done. You still have the problem, even if you do not cut the payroll tax of having the fund run out.

Mr. DARMAN. Right. And it may be that——

Senator BRADLEY. So what are your thoughts?

Mr. DARMAN. We do not have a solution yet. If you would like to, you can document in detail that I do not have a comprehensive solution, but I volunteered that point. I think if you want to look at the—if you want to define the portion of that glass that is full, it is that it will help force us to act collectively at some point. Just as the prospect of bankruptcy did with Social Security.

We are facing the prospect of bankruptcy in the system as a whole, in terms of our current aspirations and intentions, and the gap between the expected cost of that, and what we have set aside to finance it with.

Senator BRADLEY. But right now, in terms of the first, obviously you reduce health care costs that might help the fund.

Mr. DARMAN. It is not going to solve that problem alone.

Senator BRADLEY. It is not going to solve it. Help it at all?

Mr. DARMAN. It will help, sure.

Senator BRADLEY. Well, it might help a little. So you have said 18 months—is that the outside? We will hear nothing on comprehensive approach before 18 months from now?

Mr. DARMAN. Well, Senator Grassley volunteered 18 months, and I said less than. If I were to say we will have it tomorrow, you should have not have confidence in that. And as I know, we already said we were going to have it by the end of last year, and we missed that deadline. So my own credibility on this subject would have to be questioned. [Laughter.]

Senator BRADLEY. But from the standpoint of whether we move without the administration, it is important to have your views and to have an approach, at least that we can formulate a response to, or perhaps an alternative.

Mr. DARMAN. I think that I would very much hope that we would work together. We have had very good experience, I believe, working with Chairman Bentsen and the committee so far on health issues.

Admittedly, many of our recommendations have not been accepted, but we have moved forward together on some. I would think the nature of this one is such that we would have to move forward together.

Do we agree that there is an access problem that has to be addressed? Yes. Do we agree that there is a cost problem that has to be addressed? Yes. Do we agree that there is a major financing problem? Yes.

So we at least agree on some basic elements of the problem, and I think that working together, we should be able to try to define the solution. But I do believe that it is exceedingly hard to get to the point where you have a high degree of confidence in the solution you are going to recommend.

Senator BRADLEY. Thank you, Mr. Chairman.

The CHAIRMAN. Looking around at my colleagues, I know that because of the intensity of the questions and the deep interest, that they have many more questions they would like to ask. We cannot, because we have some very distinguished witnesses that will be coming.

And let me say to you, Mr. Darman, I appreciate your testimony this morning. I think it has been very good, and it shows the time, and the thought, and the commitment that you have made to these concerns.

Reflecting on what Senator Bradley has said, and some of the others, we want to move forward here in the committee. It would help a great deal if you could tell us early on the things that you think are pitfalls, or provide us with parameters, or principles on which you and the administration think we should concentrate.

I am pleased to hear that the administration is still committed to comprehensive health care reform, because the need is obvious to all of us. But thank you very much for your testimony.

Mr. DARMAN. Thank you very much, Mr. Chairman. I appreciate your having me, and thank you again.

The CHAIRMAN. Delighted to have you. We look forward to having you back.

Mr. DARMAN. I look forward to working with you.

The CHAIRMAN. Let me state that this panel of witnesses that we have next are pretty tough, able, chief executives of companies.

We have chosen them, because they are broad gauged, interested in health care, and because of the size of their companies, they have had the chance to have a great variety of experiences in health care. We think that their views will be helpful to us.

Mr. Edward Hennessy, Jr. Mr. Hennessy is an old friend of mine. Chairman of the board, chief executive officer, Allied-Signal, Morristown, NJ.

We have Mr. Kenneth Macke, who is chairman and chief executive officer of Dayton Hudson Corp., Minneapolis, MN. He has invested a great deal of work and thought concerning health care issues.

And Mr. Walter Williams, who is chairman and chief executive officer of the Bethlehem Steel Corp.

Gentlemen, we are very pleased to have you this morning. I know there are many demands on your time, and I think just your being here to testify attests to your concern and your interest in this situation. Mr. Macke, if you would proceed.

STATEMENT OF KENNETH A. MACKE, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, DAYTON HUDSON CORP., MINNEAPOLIS, MN

Mr. MACKE. Thank you, Senator. Members of the committee, Senator Bentsen, good morning. I am pleased to be here to have this opportunity to register with you my deep concern about the predicament our country's medical delivery system is in, and to offer several carefully considered ideas for reform.

As you know, I represent Dayton Hudson Corporation. We are one of America's largest retailers, with $15 billion in sales. You probably know us better as Target, Mervyn's, Dayton's, Hudson's, and Marshall Fields.

We have more than 700 discount and department stores in 33 States. We are the 16th largest employer in the Nation. That is why I am here today. We have approximately 161,000 employees. Of these, 60,000 work over 24 hours or more a week. They, and their dependents are covered by medical insurance.

I have been with Dayton Hudson for over 30 years—that is all of my career. For 6 years, I have been the CEO. During the 6-year period, our corporation's medical expenses have grown from $60 million in 1985 to $115 million in 1990. Our per-covered-employee cost has increased from $1,108 to $1,649 in those same years.

In 1985, an appendectomy cost about $2,500. Today it can easily cost $6,000. Normal childbirth in 1985 was $2,000. Today it is $4,500. Another way to see the magnitude of this is to realize that we have to sell over 39,000 Ninja Turtle action figures to pay for one appendectomy.

In the early 1980's, we began an aggressive cost containment program. We are self-insured for all by HMO coverage. We use claims management for high cost cases. We do utilization reviews. We use our size to influence HMO practices. We make use of managed care and bargained rates for transplants.

We use our size to influence HMO practices. We have tightened what we offer employees by charging significant employee premiums, including deductibles and co-payments.

We have increased the administrative requirements of the plan through second opinions, pre-admission procedures, and a host of other disciplines. And yet, in 1990 alone, our total medical expense per-covered-employee increased 15 percent.

This picture is even darker for small companies that fully insure. For that group, insurance premiums increased a minimum of 23 percent in 1990. We have learned that even in our medically com-

petitive state—Minnesota—where HMO's are a heavy influence, market forces cannot solve the problems.

Experts estimate that if we do not do something about costs now—and you have all heard the figures, but they bear repeating—our country will go from the current $735 billion to over $2 trillion, or more than 20 percent of the GNP by the year 2000.

I am equally alarmed that an estimated 37 million Americans do not have access to medical insurance. Because of the cost, universal coverage can be afforded only if we have basic reform.

Experts tell us about a third of health care is not of value, because of excessive and inappropriate treatment. Present administrative burdens represent waste. Malpractice costs—that is, defensive medicine, cost of litigation, malpractice insurance—are draining billions of dollars.

As hospitals see doctors, rather than patients, as their primary customers, they feel compelled to provide more sophisticated equipment and technology. This results in excess investment for equipment and excess cost to payors.

Research and development is decentralized and disorganized to the point that it is often inconclusive and unusable.

The Federal Government has used its power to make decisions relative to Medicare costs, and to enforce those decisions. Providers have shifted enormous charges to the private sector that otherwise would have been covered under Medicare.

The blame for this waste and inequity is widespread. It includes government, business, the medical profession, unions, and consumers of health care. The cure, we think, is reform, which gives everyone access, and provides only necessary quality care at the lowest cost.

As reform occurs, it will mean sacrifices by all segments of the medical treatment chain: providers, payors, and users.

Rapid escalation in costs will continue if we do not intervene. We do not think we can afford it. It is paramount that these changes occur as soon as possible. Waiting another 3 or 4 years will allow spending to double again and will hurt those who are unprotected.

Given the gravity of our situation, Dayton Hudson is participating in various coalitions whose purpose is to bring about health care reform that delivers quality care in the most economical manner, and delivers it to all Americans.

In Minnesota, we are a principal participant, along with five other large employers, in a strategy called Businesses Health Care Access Group. Through it, we are developing a proposal to our State legislature on basic health care reform. It incorporates standards of quality care, and outcomes-based management, that over time, provide access for all Minnesotans and control cost escalation to the annual increase in CPI.

I am serving as the chairperson on health care reform considerations for the Minnesota Business Partnership. This group has developed principles that we believe should help guide any health care debate. I think you have copies of those principles.

Reform at the State level in Minnesota may be under way during this legislative session. Even so, we believe that nationwide reform is essential.

We are a national economy. Employers and medical providers alike operate across State lines. We have a mobile population, with many people—millions—moving from State to State annually.

The need for universal coverage can be met only if there is national reform. If 50 States form 50 separate systems, then chaos is going to develop.

We are so convinced that nationwide reform is essential that we are an active member of the National Leadership Coalition for Health Care Reform. For more than a year, that coalition has been developing a strategy for universal coverage and major reform.

The American College of Physicians is working with us, as are other major medical institutions, including the Association of Academic Health Centers, the American Academy of Pediatrics, and the American Nurses Association.

Our group includes about 35 of the largest U.S. corporations—AT&T, Ford, DuPont, GE, 3M, all the regional Bells, IBM, Kodak, Xerox, Westinghouse, Wal-Mart, and Dayton Hudson among them.

The coalition also includes nine of the largest labor unions, the Nation's largest consumer groups—AARP, the United Way, and the U.S. Catholic Conference. Altogether, we represent over 100 million Americans—all working to achieve systematic reform.

Although we are still in the process of developing our strategy, I can tell you that it will contain competitive and regulatory elements, including strong financial and tax incentives to create comprehensive delivery systems that will compete on the basis of quality, efficiency, and price.

We will emphasize wellness and prevention. There will be strong cost containment provisions, limiting payment to scientifically appropriate care. We will propose a system of technology assessment, standard setting and quality assurance; building further on current efforts of Medicare.

We will recommend policies which stop cost shifting between government and the private sector, and within the private sector. The strategy will include insurance reform, including the elimination of medical underwriting, and the requirement of a community rating for small groups, so that small business is fairly treated.

We will include strong proposals for malpractice reform and administrative simplification of the system. We believe we will have a chance to mobilize the private sector, and to work with government to achieve these necessary reforms.

I would urge you to lead this Nation to make reform and access a top priority. The problem is not going to go away. We think the solution is within our reach. We are eager to help in any way we can. Thank you.

The CHAIRMAN. Thank you, Mr. Macke. We will have questions for each of you as soon as the presentations are made. Our next witness to speak would be Mr. Edward Hennessy, who is Chairman of the Board, Chief Executive of Allied-Signal, an old friend of mine——

Mr. HENNESSY. And mine, Mr. Chairman.

The CHAIRMAN. Thank you, Bill.

[The prepared statement of Mr. Macke appears in the appendix.]

STATEMENT OF EDWARD L. HENNESSY, JR., CHAIRMAN OF THE BOARD AND CHIEF EXECUTIVE OFFICER, ALLIED-SIGNAL, INC., MORRISTOWN, NJ

Mr. HENNESSY. Good morning, Mr. Chairman. I want to thank you and the committee for this opportunity to share with you Allied-Signal's experience and views on the challenge of providing quality, affordable health care.

Our company is a $12 billion advanced manufacturer serving the aerospace, automotive and engineered materials markets. In this country, we have operations in 35 states employing about 76,000 U.S. workers.

In 1988, Allied-Signal implemented a company-wide program that has been described as the boldest and most forward looking corporate effort yet devised to provide quality health care at an affordable cost. But we did not get to that point without some prodding.

Like other major U.S. corporations, Allied-Signal has learned through hard, first-hand experience the threat posed by runaway medical care costs.

For years, we had struggled to break through the chronic pattern of rising costs through measures like higher deductibles, coinsurance payments, hospital pre-admission certification, mandatory second surgical opinions, and the use of more than 100 HMO's nationwide. These measures controlled the rate of growth for a while, but all they really did was treat the symptoms without attacking the underlying illness.

In 1987, however, our health costs went on the critical care list. That year our health care bill surged 39 percent, and our projections showed a continuing annual growth rate of about 20 percent for the next several years.

We realized that we needed a totally new approach. We recognized that in order for cost containment measures to succeed, they had to be aimed not just at health care consumers, but at health care providers as well.

So, just about 3 years ago, Allied-Signal became the first major employer in the United States to create a managed health care system—uniform in design and managed by a single insurer—on a national scale.

At the heart of the program is a series of 26 health care provider networks throughout the country, organized by our insurer.

The networks now cover more than 50,000 employees, and their dependents. Employees choose a primary care physician who is a member of a network. This doctor, who serves as the coordinator of all the employee's health care service needs, is pre-paid by the insurer—CIGNA—every month.

Employees using network providers pay no annual deductible, and most services are covered in full. There is, however, a $10 co-payment for office visits, and a $5 co-payment for prescription drugs.

More importantly, the program encourages preventive care and offers annual physical exams and special services like vision and hearing exams, and well child care. As we all recognize, preventive

care is far more cost efficient over the long term than the therapeutic treatment of a disorder.

Another distinctive feature of our plan is that it preserves the employee's freedom of choice. They can, at any time, decide to use a provider who is not in the network, but it costs them.

Outside the network, the plan requires an annual deductible of one percent of yearly base pay; 3 percent for family, and a 20 percent co-payment. These costs are, of course, steeper than the in-network expense, but they are competitive with many fee-for-service indemnity plans that are available throughout the country. And, the Allied-Signal employee always retains the option of using in-network services at any time.

What have the results been? Well, our latest figures show our corporate costs have been 27 percent lower for employees using the new plan than they would have been using a typical "fee for service" indemnity plan.

Savings per employee are projected to be $1,244 this year. Approximately 80 percent of our employees covered by the managed care plan use the network 95 to 100 percent of the time.

So I think it is fair to say that Allied-Signal, as well as other companies embracing managed care programs, are tackling the health care affordability issue.

But what about the quality of the care provided? In Allied-Signal's case, we believe the quality of the health care our employees are receiving has remained high.

Certainly, the high percentage of network utilization would suggest that the level of care provided meets our employees' quality expectations.

At the same time, we have sought to reduce the sense of entitlement that surrounds health care in this country.

Our network providers are capable of offering first class health care to our employees. However, if desired, the opt out provision that I mentioned a moment ago allows an individual to seek alternative medical care. But they must come to terms with the need to pay for that decision.

Health care costs will never be brought under control in this country if there is not some elemental link between the service desired, and the need to pay for it.

To look at the situation from a different perspective, there is no evidence to suggest that our country has improved the quality of health care by throwing money at the problem.

On the contrary, infant mortality rates, and other familiar statistics suggest that the vast sums we are now spending simply are not getting the job done. In fact, I believe that the core problem is the "blank check" mentality that nearly all of us bring to our medical care.

Over the years, we have developed the expectations in our society that while an individual is responsible for providing such necessities of life as food, clothing, and shelter, medical care is an entitlement; the responsibility of others.

Competition in the market for food, clothing, and shelter yields ample supplies at reasonable costs and quality. In the medical care field, however, there is no competition. The opposite is true; doctors and hospitals tell us what we need, and how much it costs, and we

pay with no questions asked. Or to be more precise, someone else pays. And until recently, they have not been asking questions, either.

Allied-Signal's managed care program, like similar programs, is designed to forge a partnership that includes the health care provider, the employee, the company, and our insurance carrier to manage the costs and the quality of our health care services. In short, we are striving to do away with the "blank check" mentality.

But there is a clear need for the Federal Government to help wrestle this National problem back to manageable proportions.

The most urgent concern is for the millions of Americans currently without health care insurance; that is an intolerable situation.

At the same time, the relentless growth of health costs is continuing to erode our competitiveness in the international marketplace. Health care costs represent a substantial, but largely unrecognized surcharge on virtually all U.S. manufactured goods.

I can tell you that despite all the efforts on the part of U.S. manufacturers today to drive down our operating costs and dramatically improve the quality of our goods, we will not succeed in the world market if our health care expenses remain so seriously out of line with those of our principal competitors.

So what should the Federal Government do? And I do not know whether I dare suggest these recommendations, or not.

But for starters, I believe that the Federal Government should use its considerable weight and influence as an employer to adopt managed care Nationally for Federal workers. Managed care is not a panacea, but I do believe that it is part of the larger solution to the problem.

Next, the Federal and State governments should support private sector efforts to control health care costs through a renewed emphasis on employing cost containment strategies, like managed care.

Finally, the Congress must come to terms with a need for positive reform in Medicare and Medicaid programs. The current expedient of simply reducing the reimbursement level only shifts the payment burden to insured private employers, especially those who, for one reason or another, have been unable to bargain with health care providers to control their costs.

Without laying claim to special technical expertise in this area, let me cite a few ideas which seem promising: Make health care premiums completely deductible for self-employed individuals. Consider targeting tax credits to small firms that can document their inability to purchase affordable health care coverage.

Identify and remove the regulatory barriers that prevent small business from banding together to achieve greater market power in negotiating with providers.

Do not invent new systems to cover the poor and the near-poor who make up a disproportionate number of the uninsured; instead, fix the Federal program which was designed to address their needs: Medicaid.

If effective cost controls can be established, phase in expanded coverage to all who fall below the poverty level. For the near-

poor—with incomes close to the poverty line—allow a "buy-in" for a low-cost basic package of benefits.

In conclusion, I think all of us—public policymaker and private businesses alike—must recognize that we will probably never see a decrease in health care costs—not with our aging population and the baby boomers headed for retirement in about 20 years. But, even if we could bring down the annual rate of increase down into the single digits, it would be a significant victory in which we could all share. Thank you very much.

[The prepared statement of Mr. Hennessy appears in the appendix.]

The CHAIRMAN. Thank you very much. Mr. Williams is chairman and chief executive officer at Bethlehem Steel Corp., a company that faces tough international competition, and concerned about its costs, and health care being a substantial one. We are pleased to have you.

STATEMENT OF WALTER F. WILLIAMS, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, BETHLEHEM STEEL CORP., BETHLEHEM, PA

Mr. WILLIAMS. Thank you, Mr. Chairman. I appreciate the opportunity to appear before this committee to share Bethlehem Steel's—and I believe basic industry's concerns—about the health care crisis that is facing our country, and its impact on our steel industry, and the other businesses. And I have submitted a full statement for the hearing record, so I will summarize it.

The CHAIRMAN. Thank you.

Mr. WILLIAMS. I think it has been readily agreed this morning the fact is that America's fragmented health system is certainly not working.

The question is, can our society—and I want to make this point—not our government, not our companies, not individuals, but can our society afford the out-of-control health care costs that are double and triple the rates of inflation that we have seen in recent years.

Last year it cost, on the average, for every American, $2,500 per person. The answer certainly has to be "No." And the answer is also "No" for the business sector. 1990 was a disaster with health care costs for private employers increasing an average of 21.6 percent.

Worse yet, smaller companies experienced increases exceeding 30 percent. And it is also "no" for the steel industry. Currently, health care costs are $4.12 an hour worked for our steel industry, and that is over 15 percent of our employment cost.

A decade earlier, in 1981, the cost was $1.49 an hour, or about seven percent of total employment cost. Now, that is an increase of 176 percent for health care, as compared to only a 21 percent increase in all other employment costs for a 10 year period.

The result: The steel industry's health care costs are now two to three times that as to the rest of the world's steel industries.

For example, in 1990, each steel worker in Canada supported health care for active and retired steelworkers at a cost of $3,200 a year.

By comparison, each American steelworker actively working is burdened with an annual cost of $7,600 for health care covering the same group—active employees and retirees.

Now, that certainly is a staggering difference when you recognize that the steelworkers in the United States and Canada have essentially the same benefit package.

The Canadian example is not unique, and the difference is even greater in many countries. Unfortunately, the gap keeps widening.

And as you pointed out, Mr. Chairman, we must keep in mind today that steel is an international commodity, and we must compete in the global market. And unlike past years, our domestic market is in the global market today.

Getting a little closer to home for me, consider these Bethlehem Steel numbers: We provide comprehensive medical coverage for 30,000 active employees. As a result of labor negotiations many years ago, we also provide similar coverage for 70,000 pensioners.

Adding to these numbers all the dependents and spouses, we presently provide medical coverage programs for a total of 170,000 people, all being carried by a current work force of just 30,000 employees.

Fully recognizing that problem years ago, we have not been standing still. We have increased employee cost sharing, and we have put in very extensive managed care programs to try and control the health care cost. Unfortunately, these efforts represent "bandaids" which only momentarily have slowed down the escalation in cost. They do not, and they cannot attack the underlying inflation which is driven by uncontrolled increases in the charges for medical services.

Even though Bethlehem's health care program includes the full range of managed care, we saw our costs rise by 26 percent in 1990. From $162 million to $205 million in 1990. About half was due to required increased coverage, with a balance of about 13 percent due to across the board escalated costs for medical services.

One final comment on the industry's health care costs. I am concerned, as I know you are, about the need to provide some type of benefits to the 30 million Americans who are not now covered by health insurance.

We need to expand access, but we must at the same time control costs, and address the quality of services. Access, cost and quality are interdependent. And providing access without addressing the other parts of the problem will certainly not solve our health care crisis.

Currently, due to cost shifting, the private sector does not have a level playing field with respect to health care costs. And employers, both large and small, I believe, are carrying an unfair burden.

Without comprehensive reforms that benefit all health care payors, cost shifting can only make matters worse for our businesses. We must not solve the government's budget concerns with cost shifting to our industries.

In short, our health care system is in crisis. And we have many diverse and fragmented interests involved in the system. We have a systemic problem that I believe requires a systemic solution that I believe can only be addressed at the national level.

If we are to expand access and control costs, then I am convinced we must accept the need for a stronger Federal role in health care.

We, at Bethlehem Steel, believe that a national solution should consider the following principles. First, cost containment legislation to establish regional reimbursement schedules to insure that public and private payors pay the same for health care costs, and cost shifting must be eliminated.

Several states have started such programs. And I understand that the State of Maryland's program covering hospitals, has made significant progress.

I might also add that in the interest of the question that was raised by Senator Grassley earlier, and that was do the fee limits on government programs that are lower than the costs result in cost shifting? I am not so sure we had a very clear answer, but the fact is pretty obvious it sure does.

And since the only other significant payors of the system have to be private industry, I am certain that there is cost shifting from the government limitations that we are picking up in industry.

Second, annual increases in health care should be controlled by national spending targets at the Federal level. Third, we believe that companies not providing health care for their employees should be encouraged to do so, through either the use of tax incentives, or perhaps, penalties.

Fourth, a wide-ranging program to assure improvements in the quality of health care should be implemented. Fifth, Federal legislative reform is required to reduce the medical malpractice cost, and that is an essential part of this. And finally, we believe that Medicare must remain the primary payor for the elderly.

The bottom line is that we must have across-the-board reform. Competitive market forces have not worked in controlling costs, in providing access for the many people that are limited, and the band-aid solutions that we have all put into place have only been modestly effective.

We need help now, so I urge Congress to direct its attention to comprehensive health care legislation. I beg you not to address the problem piecemeal. This will not solve the problem, as the problems of cost, access, quality, cannot be addressed separately. Thank you, Mr. Chairman, for this opportunity to speak with you.

[The prepared statement of Mr. Williams appears in the appendix.]

The CHAIRMAN. Those are some shocking numbers—what you have in the way of costs per employee. And Mr. Macke, you talking about the cost of operations, and Mr. Hennessy, your speaking of patients not asking the cost or looking at competition. All of us deal in personal experiences. Let me tell you one.

I can recall when I was about 12 years old, I seemed to have recurring colds. And my parents took me to the doctor in town—small town. We lived out in the country on a ranch. And the doctor said well, he thought that I had to have my tonsils out.

My father said, now, how much is that going to cost? The doctor said, well, $35. And that was back during the depression. My father said, you know, that is a lot of money. He said do all kids have to have their tonsils out anyway? And the doctor said, well, just about. And that is what they thought in those days. So he said,

well, if it is $35 for one, would there be a discount for five? [Laughter.]

And the doctor said, well, Mr. Bentsen, you do not have five children. No, but my brother has children. And that afternoon, five of us had our tonsils out for a discount to some degree. [Laughter.]

Well, it was interesting when you were talking about managed care, and the kind of savings that you have been able to bring about. We have heard other testimony, though, that it is kind of a one time savings. You have a substantial savings, but after that the costs seemed to increase about the same, whether it is managed care, or otherwise. Has that been your situation, or not?

Mr. HENNESSY. No, sir. That is not. We got our increases down to single digit increases for the 3 years that we tried managed care. We just renegotiated our contract with the insurance carrier for the next 3 years. And we are looking at single digit increases, too, for the next 3 years. So we think it is working.

The CHAIRMAN. Well, that is encouraging. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman. I want to congratulate each of the individuals who gave statements. You people are right out there on the firing lines.

As I listened to Mr. Williams' presentation, I shook my head at the problems you face. And I was interested in the extent to which you have been able to get into managed care with your employees. How were you able to negotiate this into union contracts?

Mr. WILLIAMS. No. In our contract we have the right to have managed care, and we also have had the cooperation of the union in putting in outside of the contract where we were not locked in, to any great degree, putting into good managed care. They have supported that, and they work with us even today in trying to support it even further.

Senator CHAFEE. Mr. Hennessy, on page 5 of your testimony, you noted that savings per employee are projected to be $1,244 this year.

Mr. HENNESSY. Yes.

Senator CHAFEE. I take it that that is savings from what the costs otherwise would have been.

Mr. HENNESSY. That is correct, sir.

Senator CHAFEE. You say you have 76,000 employees, and then you say you have 50,000 workers and dependents under this managed care program, that is far less than half of your total work force.

Mr. HENNESSY. No. It is 50,000 out of the 70,000 U.S. employees that we have. We have——

Senator CHAFEE. Oh.

Mr. HENNESSY. Of course, we have employees outside the United States, as well.

Senator CHAFEE. Oh. I misunderstood. I thought the 50,000 applied to employees and dependents?

Mr. HENNESSY. No, no, no.

Senator CHAFEE. That is not a total?

Mr. HENNESSY. There is 50,000 employees and their dependents.

Senator CHAFEE. Oh. I see. I see. Okay.

Mr. HENNESSY. Now, we also—there are some areas in the country where we have so few employees that networks have not been

established. So those are excluded, but we have been able to negotiate with all of our unions, with the exception of those associated with the automotive industry, to include managed care with their programs.

Senator CHAFEE. And with the UAW, you are locked into first dollar coverage?

Mr. HENNESSY. Yes, sir. All the way.

Senator CHAFEE. And they will not cooperate in any way in trying to bring down your costs?

Mr. HENNESSY. Well, we are still working on them.

Senator CHAFEE. Well, so far they have not, anyway. Well, I think the suggestions you have are good ones, and particularly as it applies to managed care. Mr. Chairman, I just want to say we appreciate this testimony, and I do not have any further questions. Thank you.

The CHAIRMAN. Thank you. Senator Durenberger.

Senator DURENBERGER. Gentlemen, I read somewhere recently that the CEO of the average American company spends 4 hours a year on the subjects we are dealing with here today. And I have got to say you have just about got your quota in. [Laughter.]

But I wish all of the folks that spend only 4 hours would follow the model that each of you have set for the chief executive officers of their companies.

And, like my colleagues, I appreciate your patience today, and I appreciate your contributions. I am also glad you were here for Dick Darman's presentation, and I hope as you travel home you read that book that he put together.

I suspect the conclusions you are going to come to are very similar to the conclusions that at least tentatively he has come to. That is, we have got to deal with the definition of comprehensive solution. A lot of very well meaning people have come up with an awful lot of suggestions about what to do in this system, and with all the time I have spent on this, I cannot find one that is comprehensive. One that can guarantee access to everybody, deal with the quality issue, and deal with the cost issues, but I admire anyone who will spend time trying to resolve the problem.

On the issue of cost shifting, and this is by way of an observation. I have noticed in the last year or so a tendency on the part of a lot of people in the employer sector to talk about cost shifting, and it is just an occasion to remind us that the American National Health Insurance has been built on cost, or charge shifting.

I mean, from day one, those who could afford to pay have paid for the others. And that is just the American way—whether it is good or bad, it has been the American way.

The degree of cost shifting today is larger than it has ever been before. But that has been our national system. We do not turn people away from our doctors offices in this country. We do not turn people away from our hospitals. We send you the bill for them, to those of you that have the capacity to pay for it. And so, it seems to me it is important, those of us who are the reformists in this thing—keep that sort of thing in mind.

The second important point—this is the one I would like to get some observations on. I thought one of the lessons of Dick Dar-

man's presentation is that he set out some observations that we may, or may not agree on.

And his simple observation number five is that although one might think that the mass of Federal expenditures for health should go substantially to the poor; in fact, they go overwhelmingly to the non-poor.

I took, for example, the Bethlehem figures we got from Mr. Williams. And if I project that out in terms of a tax subsidy for each one of those 170,000 people, that is fairly substantial—fairly substantial.

To the degree that Mr. Williams and his unions continue to negotiate rather substantial payments into health insurance plans and so forth, it increases that subsidy, and it increases the disparity between the people who are lucky enough to have retired from Bethlehem, or worked at Bethlehem, and everybody else.

But it is difficult for us to get at that particular issue, because it is so well covered by the business community, and the employed community. And that is, to do something with that tax subsidy. And maybe one of you has learned something from your negotiations on managed care, or cost sharing, that will give us some idea of how we might approach moving that tax subsidy around to improve the use of the Federal expenditure for access to health care. Anybody want to make an observation about it?

Mr. WILLIAMS. Are you asking in particular how we would use the government money more effectively? I am not sure I understood, Senator Durenberger.

Senator DURENBERGER. Yes. I am really dealing with the role that the tax subsidy—I mean, in your case, you get a business deduction for every one of those $7,600 contributions, and the employer, or the employee does not pay any tax on the equivalent.

Mr. WILLIAMS. Yes.

Senator DURENBERGER. And as you heard here earlier, the self-employed pay for their insurance premiums with after tax dollars. And is that subsidy crucial to the provision of health insurance?

And secondly, if we were to alter that subsidy in some way—I mean, is it even possible to alter that subsidy in some way and still have you maintain your commitment to health insurance for your employees? I am looking for the forcing mechanisms that would cause some change in $7,600 a year health plans, which to me seem ridiculous.

Mr. WILLIAMS. Well, of course that—in our case, too, to make sure we understand that, that $7,600 is charged as an employment cost per hour to each one of our active employees. So, in a sense, that cost for him as he is carrying is also for the retirees.

Senator DURENBERGER. Okay.

Mr. WILLIAMS. So that is the total. That is not necessarily his cost, although his costs are quite substantial; probably somewhere in the range of—for his and his dependents—probably somewhere in the range of $3,000 a year. The balance of it is for the other 70,000 retirees that are out there.

I keep getting back to the thought, Senator Durenberger, that when we talk about the government support, the government programs, the government taxes, individuals who must pay separately

with after tax dollars, there are a lot of little areas there where there can be some fixing.

But the fact is that when you add them all up, the cost of all these groups—that is what our society must spend. So if there is more shifting onto industry, it means that we have got to get higher prices for our products, society is still paying for it.

We have got to find a way to look at it comprehensively and get costs down across the board so that no component is giving away the store, or no component is having a free ride, we are all carrying our fair share, and we get the total costs down. That is really the way I look at it. It is not who pays. We are all going to pay. And that, I think, makes the problem very difficult, which I think has been expressed here today several times.

Senator ROCKEFELLER. Gentlemen, I put this question to you to try to help you help me break a political log jam. I know all of you have given extraordinary thought to your testimonies. You have done significant things in your own companies—you have shown incredible leadership.

We are presented, however, with what you all agree is the need for a larger, more comprehensive approach to curing our Nation's health care problem. You come in and offer your solutions.

We, in Congress, however, are faced with passing legislation and that means that we must deal with some who are not, in fact, progressive business leaders.

We are faced with the U.S. Chamber of Commerce, the National Association of Manufacturers, the National Federation of Independent Business, Small Business United, et cetera, and the providers. To a person, the business groups come in and say we have this terrible problem, and yet, no, we cannot do this pay or play business. We cannot go along—even if it is over a period of 5 years and includes substantial tax subsidies and credits.

I am just telling you that many of these groups are going to fight tooth and nail—your representatives are going to fight a comprehensive solution tooth and nail.

The providers will do exactly the same on cost containment as business does on access. Providers want access, because that would be the end of uncompensated care, and for other good reasons. They are physicians and they want to help. They are hospitals and they want to help.

But you talk about more dramatic cost containment outside of practice guidelines, utilization review, outcomes research, and tort reform and you lose the providers.

You can do all of those measures to contain costs, but they all take time. Outcomes research—how long will it be before physicians agree on what constitutes appropriate medical care across thousands of medical codes? Practice guidelines take a lot of time that we do not have. We are looking for a comprehensive solution, short of national health insurance, which is becoming increasingly attractive to members of Congress.

So, how do I—how do we, in the Congress, break this log jam?

Mr. HENNESSY. Well, maybe you can have universal access, but certainly not freedom of choice if you are going to control costs. And Congress'—it is not desire, but leaning towards a national

health insurance program is not going to solve the problem of costs.

Senator ROCKEFELLER. Yes. I am ruling out national health insurance. I am talking about universal access, for example, in the manner that the Pepper Commission suggested, which is——

Mr. HENNESSY. And that was a very—and I read that report, and I thought it was a very admirable report. But it was going to cost, I think, what—$66 billion more, and nobody suggested how it was going to be funded.

Senator ROCKEFELLER. Yes. The health access recommendations cost $24 billion, and we suggested six ways to pay for it. So, see, that one will not float.

Mr. HENNESSY. Right.

Senator ROCKEFELLER. I believe cost containment is the gateway to access. I accept that.

Mr. HENNESSY. Yes.

Senator ROCKEFELLER. Try to talk cost containment to the medical community, the provider community—even mention the word all payor—even mention it, and everybody is out the window. Mention the word mandate to the business community, they are out the window.

Mr. HENNESSY. Yes.

Senator ROCKEFELLER. Even if you talk about over time, with subsidies, with credits, doing back flips, whatever is necessary, and insurance reform. All of those things. How do I break the log jam? How do you break it with the folks that represent you?

Mr. HENNESSY. Well, we had to break it. We had to break it, or we just would be out of business today. We just could not go on the same way we had been going on.

Senator ROCKEFELLER. Well, maybe I am suggesting that your responsibility then as leaders, which you are, is beyond your own companies and is towards those organizations who represent you.

Mr. WILLIAMS. I think something will be coming out of some of the organizations—the groups that are now formed. Mr. Macke referred to the one, the National Alliance, which we are also a member of. And it is quite large, working quite hard, and we are getting somewhere internally. You are going to have—and I understand the frustrations that you have, we have them, too; some diverse views from NAM, BRT—Business Round Table, whatever they may be.

We have got to get something pulled together quickly, and we are looking at a broad business coalition that is outside at this present time—NAM, or BRT, or anything else—and working hard to try and come up with some solutions. At that point, I think we have an obligation to try and sell our point of view to the organization, and to you, and to the public. It will not be easy. Someone—and I guess we would have to take our share, too—someone has to suffer some pain in all of this. And I am not so sure I know who that is right now.

Senator ROCKEFELLER. No. The answer is that everybody has to suffer pain.

Mr. WILLIAMS. Everybody has to suffer some.

Senator ROCKEFELLER. Or else it will not work.

Mr. WILLIAMS. Or else it will not work.

Senator ROCKEFELLER. But somebody has got to—and they are not taking leadership on health care at the other end of Pennsylvania Avenue, with all due respect. They may begin to, but they have not done so up to this point.

I suggest that your responsibilities are larger than your corporations. You are big enough and powerful enough to do what you want, but you must address the small business market, which is where so much of the problem is. I do not mean to scold, because you are exemplary. I am pleading.

Senator CHAFEE. Well, Mr. Chairman, I would just like to make this point. That as Mr. Darman pointed out, this is a very, very complex issue. There is little consensus even among small groups, such as I suspect, amongst the Democratic Senators, of which there are too many, but still not that many. [Laughter.]

I doubt if you are going to get agreement on anything in how to proceed. So the idea that there is a magical solution out there, and there is a bunch of canvass-back industrialists who fail to face up to it and come in here and say no to mandated coverage, or pay or play, or whatever it might be, that they are all stuffed shirts that do not know what they are doing, seems to me is missing the point around here.

And a lot of us—well, you are looking at three of them now who are Senators who have spent an awful lot of time on this, but trying to find any unanimity in what is the solution is very, very difficult. So I would just like to ask Mr. Hennessy one quick question, because I know we have two other panelists.

Under your managed care program, you have no deductible as I understand it, is that right?

Mr. HENNESSY. Under our managed care——

Senator CHAFEE. Yes.

Mr. HENNESSY [continuing]. Every employee, with their family, is paying between $30 and $40 a month.

Senator CHAFEE. Oh. I see.

Mr. HENNESSY. Yes.

Senator CHAFEE. Okay. I wondered—I was just curious whether if you do not have a deductible, whether—how that affects utilization. In other words, my question really is this. From your experience, if you make people pay something for their program, even though it is managed care, whatever it might be, does it reduce utilization?

And, of course, you always worry; you do not want to reduce utilization so much that people will not use it, and then get sicker than they would have been. You end up with a higher cost in the end.

So the question we are all presented with here under Medicare, for example, is a 20 percent co-payment. It seems to me something in that range makes sense. I was just wondering if you have got any anecdotal, or other thoughts on it.

Mr. HENNESSY. I do not think I can answer you, because we are developing our statistics as we go along. We had 3 years of the program under our belt. We have 3 years ahead of us now. In another 3 years, I can be able to answer you, but I think 3 years will be too late.

Senator CHAFEE. Yes.

Mr. WILLIAMS. Senator Chafee, we do have deductibles for our salaried people. For example, it is $300 per family. We have a deductible with our union. We also have 20/80 cost sharing for quite a few of the services covered under the union contract. And we have a thousand dollar out-of-pocket cost for non-covered services for our salaried people. We have had all these in place. We put them in place within the last 4, or 5, or 6 years.

I think that you would assume—you can assume that people are a little more careful if they have a deductible, but I can sit here and say that—and I have no knowledge—I just do not have the feeling that there has been a tremendous reduction in our costs because they are paying the first $100, or the first $300, or whatever it may be. I just feel it is not there.

Senator CHAFEE. I would have a belief that the deductible is not as great a deterrent as a co-payment is. In other words, once you have reached the deductible, you figure what the heck.

Mr. WILLIAMS. That is right.

Senator CHAFEE. But again, you have got this careful balance. We all recognize that we want people to use preventive services, for example. Thank you, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Senator Chafee. And in that I was not going to have a second round of questions because of time, I hope that you gentlemen will accept my thanks, and my particular appreciation for the extremely careful thought that you have given to this issue therefore, you constitute the leadership that we need in this country. We just need a lot more of it. Thank you gentlemen, very much.

Mr. HENNESSY. Thank you.

Mr. WILLIAMS. Thank you, Mr. Chairman.

The CHAIRMAN. We will combine our third and fourth panels into one panel. Rhoda Karpatkin is executive director, Consumers Union. Dallas Salisbury is president of the Employee Benefit Research Institute, and we welcome them both.

STATEMENT OF RHODA KARPATKIN, EXECUTIVE DIRECTOR, CONSUMERS UNION, YONKERS, NY, ACCOMPANIED BY GAIL SHEARER, MANAGER FOR POLICY ANALYSIS, CONSUMERS UNION, WASHINGTON, DC

Ms. KARPATKIN. Senator Rockefeller, and members of the committee, I am Rhoda Karpatkin, the executive director of Consumers Union, and publisher of "Consumer Reports." I am accompanied by Gail Shearer, Consumer Union's manager for policy analysis, who will also be available, should you have questions following my testimony.

I greatly appreciate this opportunity to share our views on the crisis in American health care. In recent years, few topics have so dominated our concerns as the cruel failure of the health care system to take care of all of our citizens.

Most recently, "Consumer Reports" published a two-part series, The Crisis in Health Insurance, in the August and September 1990 issues. The reader response to these two articles was dramatic. The letters were personal and moving accounts of tragedy and despair because of the lack of access to affordable health care.

For example, one reader, with an annual income of $11,000, wrote that a hospital refused to perform his wife's needed cancer operation because of his inability to pay $7,000 up front.

The lack of health insurance can also kill. "Consumer Reports" told the sad story of John Andrew Sichin, who died of a malignant melanoma after he delayed going to the doctors, because he could not afford to pay another medical bill. He was not eligible for insurance from his employer until he had been on the job for 1 year.

Women without adequate coverage are particularly at risk for negative health outcomes. Uninsured women are much less likely than insured women to get screened for breast cancer, cervical cancer, or glaucoma.

If they are pregnant, they often do without prenatal care. Five million women between the ages of 15 and 44 are covered by private health insurance that does not include maternity coverage. Lack of prenatal care translates into babies who are born too small, and babies who die soon after birth.

Our health care system is the costliest in the world. The United States spends 171 percent more per capita than Great Britain, 124 percent more than Japan, 88 percent more than West Germany, and 38 percent more than Canada. We pay more, but we get less. We lag woefully behind numerous countries in important health indicators, such as infant mortality.

As this committee is well aware, about 37 million Americans are not covered by health insurance at all, and about 60 million may be underinsured for much of any given year.

Individuals without health insurance have many faces. They may be poor, since only 30 of the poor receive Medicaid. But increasingly, lack of insurance coverage is a middle class phenomenon, as well.

With the present patchwork private insurance system, everybody, rich and poor, employed and unemployed, male and female, young and old, is at risk of being without health insurance.

Even those of us who feel our employer-provided policies protect us, could be just one illness or one accident, or in today's economy, one lay off away from losing both our health insurance and our life's savings.

Our August 1990 article told the story of David Curnow, formally a partner in a San Diego law firm. He was injured and disabled when—while riding his bicycle—he was struck by an uninsured motorist. His insurance carrier paid most of his bills, but he has considerable out-of-pocket costs for home-health aide services that he needs every day. When his benefits run out, even if he qualifies for Medicare because of his disability, he will still have substantial, uncovered expenses. Even if he can return to work, he probably will not find a firm with an insurer willing to accept the health risk he poses.

Mr. Curnow's tragic tale demonstrates how an accident can suddenly create a health insurance problem of dramatic proportions for somebody who, not long before, was healthy and gainfully employed.

The middle income consumer can be affected in many ways, as well. Since many employers have dropped or cut back on their health insurance benefits, many employees, especially individuals

working in small firms, can now lose access to an affordable health insurance policy.

Spiralling health care costs are leading to high premiums that force the middle income consumer—both employees of firms, and the self-employed—to drop coverage in too many cases.

Equally disturbing, the number of employers paying premiums is declining. In 1984, Hewit Associates, a benefits consulting firm, found that 37 percent of large employers paid full premiums for their workers. By 1988, only 24 percent provided these benefits.

Working Americans can lose their health insurance when their employer goes out of business. A bleak marketplace is faced by individuals who must replace a group policy with individual family coverage. Even less than adequate coverage may cost thousands a year, with premiums ever rising. Individuals shopping for coverage soon discover that insurers want to cover fewer and fewer people.

Insurers compete ardently for the healthiest applicants, while no carrier wants to cover individuals who have had a history of cancer, heart disease, or life threatening illnesses. Increasingly, insurers are turning down people with far less serious health conditions.

Virtually no commercial carrier, and only a handful of Blue Cross and Blue Shield companies will sell policies to anyone who has had heart disease, cancer, diabetes, strokes, adrenal disorders, epilepsy, or ulcerative colitis. Treatment for alcohol abuse, depression, or even visits to a marriage counselor can mean rejection by a company.

If you have less serious conditions, you may get coverage, but on unfavorable terms. Some insurers will offer coverage, but only if the pre-existing condition is excluded. The clear message to consumers is that only those in excellent health need apply. People who have medical problems, however minor, are second-class citizens in the world of health insurance.

Other middle income consumers are affected by the health insurance quagmire, because their health insurance concerns lock them into their present jobs. Pre-existing health conditions, and the fear of losing critical health benefits keep them from being able to change jobs, or change careers. We should worry that fears about health insurance are stifling the mobility and motivation of workers in the American workplace.

The health care problem has many dimensions, including the critical need for cost control. When the uninsured cannot afford health care, everyone pays. When the uninsured cannot treat health conditions when they first occur and receive costly care in hospital emergency rooms when a crisis develops, once again, everyone pays.

The emergency room in urban hospitals is becoming a primary care facility for a huge number of Americans. In 1988, unpaid hospital bills totaled more than $8 billion, zooming up 10 percent from the previous year. How do doctors and hospitals recoup these costs? They simply raise the price for everyone else.

This cost shifting, in turn, further drives up the price of insurance, resulting in still more people being unable to afford coverage. Costs ride an up elevator to ever higher levels, while consumers ride a down elevator to lower coverage. Cost shifting accounts for

about one-third of the increase in insurance premiums which are rising in the range of 50 percent a year. The cost of medical care—which is skyrocketing to two or three times the rate of inflation—accounts for the rest.

During the past 50 years, health care expenses—as a percent of gross national product—have grown dramatically. In 1940, national health expenditures were 4 percent of GNP. In 1975, 8.3 percent, and in 1987, 11.1 percent. If present trends continue, health care will consume 15 percent of GNP in the year 2000.

Insurance companies are finally beginning to pay close attention to what their dollars are buying. They have begun to monitor quality, and appropriateness of treatment. These measures may have some minimal effect on costs, but they have added yet another health care cost—cost management.

This is one of the fastest growing fields in the health care area. Health care cost management firms are expected to generate $7 billion in revenue in the next few years; revenue that will, of course, come from insurance premiums. These expenditures contribute not one iota towards improving health care for the people who need it. "Consumer Reports" concludes that the best approach that could provide both universal access to high quality health care and control costs is a model that features a single payor, rather than the system we have now; thousands of private carriers chasing the business of the healthiest applicants, while shunning those who need the coverage the most.

Meaningful reform must provide for universal access to health care; cost containment; mechanisms to ensure the quality of care; elimination of administrative waste; and long-term care for the elderly and disabled.

We should take the best out of the Canadian system, and add effective cost containment, such as practice guidelines for physicians, and assessments of the effectiveness of costly, new technologies.

While we recognize the difficulties of moving comprehensive reform due to entrenched interests including insurance companies, providers, doctors, and even some taxpayers, we urge you to rise above these interests in order to create an equitable health care system.

We are encouraged that the Senate Finance Committee is undertaking a serious examination of the American health care system. Consumers Union looks forward to working with this committee to move the concept of universal access to health care towards a reality to our nation. Thank you.

[The prepared statement of Ms. Karpatkin appears in the appendix.]

The CHAIRMAN. Thank you very much, Ms. Karpatkin. Mr. Salisbury, please.

STATEMENT OF DALLAS L. SALISBURY, PRESIDENT, EMPLOYEE BENEFIT RESEARCH INSTITUTE, WASHINGTON, DC

Mr. SALISBURY. Senator, it is a pleasure to be here. The Institute has worked for some years to try to bring new information to this area. It has been pleased in the past to give leaves of absence to Robert Friedland to work with the Pepper Commission, Deborah

Chollet to work with the Advisory Council on Social Security, as well as to fund such things as a monthly series of Gallup surveys to try and add to the store of knowledge that Bob Blendon so well described at your last hearing.

Those surveys are beginning to assess the importance to the American public—employed and not—of health insurance relative to other aspects of compensation and relative to other employee benefit programs.

We find that 61 percent of workers say that if they could only have a single benefit, they would keep health insurance. They would give up pensions, disability, and many other things. Yet, many employers instead of moving towards a more generous health insurance benefit, are spending dollars adding more and different additional benefits of lower priority, while increasing the employee's expenditure to maintain health insurance.

If we look at what individuals want, we find that they want those things that add additional cost. They want additional physician time; they want additional physician concern; they want additional access; they want to spend less.

Given public policy options, we find that they want the guarantee of not losing health insurance coverage when they change jobs, or for whatever other reason. Their preference for national health insurance or an employment-based program is evenly split until one introduces the concept of cost.

Eighty-four percent favor an employer mandate if there is employee cost sharing involved, whereas with national health insurance, if the issue is additional taxes, support declines to 27 percent.

This implies that there is strong reason to believe that the American public, faced with the necessity of paying for health care, is willing to pay more than they pay today but prefers an employment-based system, regardless of its flaws.

We have seen dramatic increases in health care spending. Mr. Darman's presentation this morning graphically showed the tremendous influence of an aging population on health care costs. The last witness noticed the tremendous growth in health care costs as a percentage of GNP since 1940.

It is also interesting to note that in 1940, a very, very small percentage of working or retired Americans had any health insurance financing access. The percentage of GNP devoted to health care has been a direct result of expanding financing access to American workers, and to American retirees, and their dependents.

If we look at the degree to which age affects health insurance premiums, one only need look at a table in my testimony which, although not so labeled, is our own Blue Cross/Blue Shield premium structure here in Washington, DC. It ranges for family coverage from $370 per month for a 29 year old, to over $1,000 per month for a worker over the age of 55.

It is that type of, if you will, cross subsidization, and cost shifting that makes health insurance most valuable if it is paid for and able to be paid for on a per capita basis. The problem of many small businesses today is the age rating fundamentally changes their employment incentives, and the cost of providing health insurance.

This is yet another area to add to the long list of others that have been described today that needs to be looked at, potentially

reformed, and understood in terms of its implications for health care purchase decisions.

To put into perspective health care spending, however, there is one statistic that while compelling, and while pointing out a problem, I always find a little troubling. And it is the fact that was in Darman's testimony, and a new report from HCFA that notes that 103 percent of corporate after tax profits are currently being consumed by health care.

I would simply note in the testimony a companion statistic. In the same year, 1,492 percent of after tax corporate profits were spent on wages and salaries and 1,784 percent of after-tax profits were spent on total compensation.

Employees want health benefits and they are willing to pay for them. They understand they are paying for them frequently, if not always, through the total compensation package. Focusing on health care as a percentage of profits probably does not move us very far towards reaching solutions.

If we look at the recent managed care initiatives of the members of the last panel, we can see that they have been able to contain cost growth. But even the managed care plans of the last witnesses are still recognizing health care spending increases in excess of CPI; a relatively important differentiation shown by Mr. Darman's charts.

I will not go through the statistics on the current uninsured. You are well aware of them. We do have a new report that was released last week on the March 1990 CPS that has been made available to the committee.

The uninsured do generally have access to health care, as was noted here. They do not readily have access to financing. There is, because of the cost shift that would be involved—as was shown by your report graphically—reason to at least understand why there is the lissension in the business community between large and small employers; between those who today pay, and those who do not pay in reaching a consensus.

The options are many, but as noted in the last statement and a question, a global budget may not solve the problem. If we look at Canada, we find that Canada's health care cost growth in excess of inflation for the last 10 years has been almost as great as the U.S. health care cost growth.

A global budget may be well worth looking at. It may have useful approaches. But as the last witness noted, situations like Canada cannot immediately be cloned to the United States and solve both of two principal problems. It can solve access. It cannot solve the tremendous, long-term increases in the national commitment to health spending.

And I dare say the access problem would be much easier for all of us to solve if it were not for the overriding emphasis of Mr. Darman's statement, and really the reason that the last three witnesses were at this table, which is a principal and primary concern over cost, and a desire to spend less, not more, on health care. Research across the board in the last 13 years, makes it very simple to understand there is no conceivable way to provide universal access, and to provide quality health care for all Americans, and to simultaneously spend less money as a nation. And the dilemma of

comprehensive reform is the dilemma of having individuals clearly understand that, and then deal with it. Thank you, Senator.

[The prepared statement of Mr. Salisbury appears in the appendix.]

The CHAIRMAN. Thank you, Mr. Salisbury, very much. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman. I would just like to ask Mrs. Karpatkin a couple of questions, if I might. As I gathered from your testimony, you did not quite say it, but it seems to me that you do support something like the Canadian system. Is that fair to say?

Ms. KARPATKIN. We support the Canadian system, but we think that Americans can improve on it.

Senator CHAFEE. Now, under the Canadian system, they take several steps—and I presume you are aware, for instance, under the Canadian system, a malpractice case is typically decided by a judge without a jury. Are you aware of that?

Ms. KARPATKIN. No, but I——

Senator CHAFEE. You would accept that?

Ms. KARPATKIN. I accept it, right.

Senator CHAFEE. And in Ontario, for example, contingent fee is prohibited by law under the Canadian system—the largest province of Canada, population-wise. So you do not have contingence fees. I am just going through a series of questions.

Ms. KARPATKIN. Yes. Yes.

Senator CHAFEE. Under the Canadian system, the losing party always pays the attorneys fees on the other side. Is that an acceptable aspect of that system. When people say they are for the Canadian system, I want to make sure they are for some of the less appealing sides of it, if you would. Do you support that?

Ms. KARPATKIN. Well, here is a way of looking at that, Senator Chafee. The Canadian system I am talking about is a system of providing access to health care for an entire nation, and they have done a very good job of that, spending less per capita than we do.

I think that we have the wit, the talent, the ingenuity, and maybe even the technology to do an even better job than they do, because we can build on what they have got, and we can benefit from their weaknesses, and devise new solutions in our own way. When we do that——

Senator CHAFEE. But if we—excuse me. My time is short, and we have really all got to quit here, because we are—both of us are due at luncheons that started at half past 12:00. I was just curious.

Under the Canadian system, pain and suffering is subject to a judicial cap index, currently around $200,000 total. So I just wanted to use this opportunity to point out some of the things the Canadian system has that I think we would all like to recognize. In other words, they have malpractice insurance reform.

Ms. SHEARER. Yes. If I could just expand on Ms. Karpatkin's response.

Senator CHAFEE. Yes.

Ms. SHEARER. I think that you would find that consumer groups are willing to accept true reform of the medical malpractice system, if it were in return for a system of universal access. And that has been the stumbling block, I think, for many, many years.

And the whole calculation shifts if we are talking about universal access and totally covered hospital and doctor bills.

Senator CHAFEE. You would be willing to accept the malpractice reform under those conditions.

Ms. SHEARER. Certain——

Senator CHAFEE. Yes.

Ms. SHEARER. Yes. I cannot tell you the exact details, but certainly some.

Senator CHAFEE. Okay. Fine. Thanks an awful lot, and I am sorry this is so rushed.

Senator ROCKEFELLER. Thank you, Senator Chafee. What you just said, Ms. Shearer, I think, is very interesting, and very important for those of us in Congress to understand.

I would like to ask all three of you a question which I was going to ask the head of Dayton Hudson, but did not have a chance to, dealing with basic benefits.

I found that in dealing with small business, and large business, that they have tended to put down the concept of mental health as a basic benefit, because the fear is—they do not always say, but I suspect—there is a fear that this benefit would be abused and therefore raise premium costs.

The Pepper Commission plan had limited mental health coverage as a basic benefit. I happen to think mental health coverage is very important, including substance abuse.

Forty percent of the work force is abusing alcohol or drugs. Therefore, rehabilitation has a lot to do with productivity, which has a lot to do with profits.

Blue Cross/Blue Shield costed out the mental health component of the health benefit package in the Pepper plan. It came to about 6 percent to 9 percent of the total premium cost.

I would like very much if each of you would give me your thoughts about whether or not that seems like a reasonable cost, and whether you think that mental health, including—substance abuse, ought to be included in a so-called basic benefit package.

Ms. KARPATKIN. Well, I would like to share the answer with Ms. Shearer. I will answer the part about whether it is important. I think it is very important. In addition to being the executive director of a consumer organization, I am the CEO of a small, if you might say, enterprise.

And our annual budget is substantial enough to support the 340 employees. We think that is important enough to include in our benefit package, and even over above that, to voluntarily have a program that helps employees with mental health problems. So just from the point of view of values and policy, I think it is significant.

Senator ROCKEFELLER. Ms. Shearer?

Ms. SHEARER. I do not have very much to add, other than the Medicare program, as you know, treats mental health slightly differently than it does other health expenses.

And if it comes down to a choice between expanding access for cancer treatment to a child, or to pay full mental health benefits—I realize I am not answering the question—but it does pose a real dilemma. Ideally, we could include everything in the basic plan, but that is not an easy question.

Senator ROCKEFELLER. So you are saying, at the very least, that you are not at all convinced that it is a necessary benefit.

Ms. SHEARER. I think some mental health. Perhaps a different cost sharing formula could be arranged, but I think that some provisions should be there. I guess I am raising the question of whether it might have a slightly different formula than other acute care health expenses.

Senator ROCKEFELLER. That is interesting. Okay. Mr. Salisbury?

Mr. SALISBURY. The cost figure seems in the ball park with the first half of your question being a statement that the reason for resistance is a fair reason, which in a very small business, it can suddenly, with one or two cases, without strict limitations, end up being a far greater cost.

And if you are a small business and are being experience rated, then against providing all of your employees with "basic" benefits, it is the fear of the potential of it exploding your premium. Having said that, we do have those benefits in our own package, and it is part of the reason our expenses are where they are in terms of the premium level. I would go to the——

Senator ROCKEFELLER. How much of the cause?

Mr. SALISBURY. They will not break it out for us, but I know that with three individuals who—two who are still working with us, and one who is no longer with us, that there were extensive expenditures involved. But it would be a confidentiality problem, they tell me, on their behalf——

Senator ROCKEFELLER. I understand.

Mr. SALISBURY [continuing]. To identify, and to identify costs.

Senator ROCKEFELLER. I understand.

Mr. SALISBURY. It then becomes a priority issue in a basic benefits package, and I would agree, in terms of the overall cost of the package. But I think there would be general agreement in the employer community, as well as in the insurance industry that access to mental and drug abuse benefits is proven to be an exceptionally important area.

And if anything, given stress-related evidence and general evidence, it, on the one hand, is going to be even more important in the future, and on the other, is exactly the reason there is concern about it—that if it is an area of increasing need, it is also going to be an area of increasing cost.

In the provider community—and I will caveat—I have some relatives that specialize in mental and drug abuse as a psychiatrist, the provider community, in the last 7 to 8 years, for the first time has become heavily organized in this area.

And on the one hand, that says that the level of professionalism in it is likely to go up; the amount of training, et cetera. But on the other hand, at the point that a new provider set of interest groups finally organize themselves around an issue area, on the buyer's side, that is something that runs up a certain red flag that says, good gosh, watch out now.

And so, you end up as in all of these things, with a contradiction between on the one hand what one says in an ideal world should be covered, and should be provided for, against the concern that I note, was the concern of the three last witnesses in general. They are here because of concern over cost.

Senator ROCKEFELLER. I understand. I want to get to another question—one for each of you. Mr. Salisbury, one of the things I think people take for granted is when they say that somebody has health insurance that includes coverage for dependents. You and I both know that there has been a change in that, and that increasingly, businesses are moving away, as a way of holding down costs, from including dependents in the plan. Could you describe what has happened in the last 5 or 10 years on that problem?

Mr. SALISBURY. If you take 5 years based on BLS data, basically——

Senator ROCKEFELLER. BLS being Bureau of Labor Statistics?

Mr. SALISBURY. Bureau of Labor Statistics. Basically universally employers were providing family coverage, and were paying the vast majority of the costs for that family coverage.

In the past 5 years, we have seen a movement in two ways. One is that employers generally are now automatically requiring individuals, even if they provide family coverage, to pay a significantly increased premium for family coverage, compared to individual coverage.

And there is a very small statistical quirk. It still appears to be well below 5 percent that are saying family coverage will be paid for 100 percent by the worker; all that the employer will pay is the single coverage.

But we are clearly seeing a movement—a beginning movement in the direction that you described. In small employer settings, particularly, we find less than 100. We find much less provision of family coverage. But against your question of the last 5 years, that is really not a change. Small businesses historically have provided principal coverage of the not-paid-for dependents coverage.

Senator ROCKEFELLER. Thank you, Mr. Salisbury. Ms. Karpatkin, there were several references made during the hearing this morning—including by Dick Darman that people take health care as a right. People do not assume, therefore, that they will have to pay for it.

As a representative of Consumers Union, I would be interested in your general thoughts on the state of the typical American family's understanding of the dimension of the health care cost problem.

And second, based upon the extent of that knowledge, the willingness of people to share in the cost of health care.

Ms. KARPATKIN. I think there is a very clear understanding on the part of the American person, worker—everyone in the United States understands the problem, because it affects everyone. The way the problem presents itself, however, is a question of where do you stand in this crazy patchwork? Are you lucky, or unlucky? Are you going to get the breaks, or are the breaks going to go against you?

So if you are working for an organization, or for the U.S. Government, or for any of the corporations that have good health care programs, you are among the lucky. And in one way or another, you are covered, and your needs are looked after.

If you are not one of those favored people, then you try to devise a strategy of averting the costs by not providing the care you need to your family, or shifting the cost to the hospital emergency room, or impoverishing yourself because you are going to spend some-

thing on health care that you should have spent on food, or on education, or on something else.

People understand the nature of the problem, and in each family—except for those that are among the favored—there is a scrambling to fight the disadvantage that you are trying to cope with. It is overwhelmingly unfair, and irrational to put American citizens in such a position. And most especially, people who are hard-working, and are doing what you are supposed to do to have a piece of the American dream.

The middle income people who live the virtuous life, you might say—even in today's terms—are people who should expect that one way or another their health care needs will be taken care of. Do they expect to pay for it? Yes. Do they expect to make a contribution? Yes. Do they want it to be rational? Yes.

And in our article, we cite two polls that have been done recently of Americans asking about whether they would like the Canadian system, where, in fact, it is a tax-based system, and so everyone pays. And the answer came back in each of those polls that over 60 percent of the people polled would like such a system.

So yes, people are willing to pay, but what they want to pay for is something that is fair, vis-a-vis all the other citizens in the country; that is fair vis-a-vis the way the providers make out; the doctors make out; that is rational, and that works for everybody in some comprehensive way. Then I think you will find that people are willing to pay.

If, however, there is a group—an entrenched group that does not want to, that does not dispose of the question. I think we are now at such a crisis point that Congress has to find the right answer and go forward, even if it means that a lot of the special interests that have been arguing for one form or another of the continuation of this system, even if those special interests are thwarted.

Senator ROCKEFELLER. When you said the Congress, I hope that you would also include the President.

Ms. KARPATKIN. Most especially, but I am more hopeful here.

Senator ROCKEFELLER. Yes. On that realistic note, let me say that I would love to go on. I am very, very grateful for your testimony.

Ms. KARPATKIN. But we appreciate you, sir.

Senator ROCKEFELLER. Yes. Your perspective is vastly helpful, you have all prepared for this, and I am very, very grateful. Thank you very much.

Mr. SALISBURY. Thank you, Senator.

Senator ROCKEFELLER. This hearing is adjourned.

[Whereupon, the hearing was concluded at 1:19 p.m.]

APPENDIX

Additional Material Submitted

Prepared Statement of Robert Blendon

Mr. Chairman, I would like to thank you for inviting me to testify today. My name is Robert Blendon. Currently, I am professor and chairman of the Department of Health Policy and Management at the Harvard School of Public Health. In addition, I am deputy director of Harvard University's Division of Health Policy Education and Research. Prior to this appointment, I served as Senior Vice President of the Robert Wood Johnson Foundation in Princeton, New Jersey.

In 1989, the Department of Health Policy and Management at the Harvard School of Public Health launched the Harvard Program on Public Opinion and Health Care. The program's focus is on the roles that public and leadership opinion play in the formation of health policy in the U.S. and abroad. We have published a number of reports on a range of topics including access to services, health insurance coverage, and attitudes about satisfaction with health systems and services. We also work with a number of different survey organizations to develop and conduct our own surveys and to advise on the design of health surveys which will be relevant to health policy research and development.

Recently, we have focused our energies on assessing the emerging debate about health care system reform in the United States. We have reviewed over 300 surveys conducted in the past four decades on health reform issues. In this discussion we focus on public support for a national solution to the problems of our health care system. More than fifty proposals for the implementation of national health insurance have been put forth the post-World War II period. Presidents Truman, Johnson and Nixon saw comprehensive initiatives fail, although Medicare and Medicaid were enacted during the Johnson presidency. In addition to the well-publicized opposition of professional groups to these proposals, public opinion during these eras was divided about making such major changes in the health care arrangements of Americans. In the absence of a consensus among supporters of reform about the type of plan that should be enacted, the opposition gained strength. It is clear that this scenario could be repeated in the current debate unless common ground is found. Our own research and our review of other studies has highlighted several themes in our nation's attitudes toward health care system reform which we will outline here.

PERCEPTION OF A NEED FOR CHANGE

The need for change in the current U.S. system is widely recognized by leadership and policy groups and by the public. Although the United States spends more on a per person basis for health care than any other industrialized country ($2,051 U.S., $1,483 Canada, $1,093 West Germany, $915 Japan, $758 United Kingdom), we fail to provide access to health care insurance to all our-citizens and our system is viewed more negatively by its populace than are the systems of several other industrialized nations. The results of a 10-nation survey conducted by Louis Harris and Associates, the Institute for the Future, and Harvard indicating a support for fundamental change in or complete rebuilding of health care systems are shown in the attached figures.

The force behind the call for reform in the U.S. is principally driven by two concerns: cost and uncertainty about maintaining health insurance benefits. In answer to an open-ended question about the most serious problem facing the U.S. health care system, the Roper Organization reports that 56 percent of respondents cite cost as the principal problem, and 32 percent say access to health insurance or services is their main concern. These findings are confirmed by other studies. Eighty-four

percent of respondents to a 1990 Conference Board survey said the cost of medical care was a very serious or serious problem, greater than crime, pollution, AIDS, homelessness, poverty, unemployment and 14 other items. Only drug abuse ranked equally with medical care costs. The rising cost of health services is perhaps more clear to Americans because they pay a substantial portion of those costs out-of-pocket. On average, Americans pay 26 percent of their health costs themselves, and nearly 20 percent pay more than 40 percent directly. This compares for example, with approximately 10 percent of bills paid out of pocket by citizens of Scandinavian countries. These conditions lead to a great deal of public uncertainty about their ability to cope with these costs in the future—although 68 percent of Americans are confident that they could cover their health costs if they had a serious illness today, 60 percent are worried that they will not be able to handle the costs in the future.

Rising health care costs are also the clear driving force behind the more recent involvement in this debate by many corporations in the U.S. Per capita costs in the U.S. rose from $1,016 in 1980 to a projected $2,425 in 1990. Large corporations say that the cost of providing health insurance benefits is hindering their ability to compete in international markets, small businesses claim that proposed government requirements for employers to provide insurance coverage would put them out of business. Disputes over health benefit premiums were the second leading cause of labor strikes in 1989. Employers surveyed by *Business and Health* magazine indicated that increasing premiums, deductibles and copayments were the options they would most likely use to cut their health care costs in the future.

The general public is getting the message from business. Today, more than 30 million people in the U.S. are without health insurance coverage, a figure that has grown by 25 percent since 1980. Because of its largely employment-based structure, the U.S. health care system provides little guarantee of continuing health insurance coverage to almost any individual and the threat of losing the coverage they have is quite worrisome to many Americans. While being without insurance is not a personal problem at any point in time for more than 15 percent of Americans, a 1989 Census Bureau survey underscores that Americans have reason to be worried. More than one in four Americans (28 percent) reported having been without insurance in the 28 month period prior to the survey. In 1989, a majority of insured persons were afraid they would lose their coverage if they changed jobs, or having a health problem or a work schedule that would disqualify them from obtaining coverage through many employers' policies. A 1990 *Los Angeles Times* survey found one in six adults (18 percent) reporting that their insurance benefits had been reduced over a two-year period, and since 1980 the share of health premiums paid by employers has declined from 80 percent to 69 percent, leaving employees to pay the difference.

SUPPORT FOR A NATIONAL HEALTH INSURANCE PLAN

All of these factors have led Americans to look for ways to change a system that they believe needs major reform. Despite the fact that a number of polling organizations have surveyed Americans on these issues using a wide array of questions and concepts, there is remarkable consistency in the public's response to the two central national policy options that have been suggested in the U.S. One such model is a national health insurance scheme that would cover all Americans and be financed through taxation or Social Security. The model for this system that is most frequently cited is that in place in Canada, though given the lack of familiarity with this system in the United States it might be more commonly understood as Medicare for the entire U.S. population. In surveys conducted by Louis Harris, NBC, Gallup, the American Association for Retired Persons, the Roper Organization, the *Los Angeles Times,* and state polling units in Connecticut and Kentucky, approximately 65–70 percent of Americans support this type of approach, even given variations in question wording. In 1990 we reported that even during previous proposals to implement such a system in the United States, support had never been higher, and that support for a national health insurance program was at a 40 year high point.

The second approach to health reform that has been put forth, both by Richard Nixon in 1970 and in another form by the Federal bipartisan Pepper Commission in 1990, is a plan that would require all employers to provide private health insurance for their employees and create public insurance programs for the unemployed and poor. This type of program would address the fact that two-thirds of the uninsured in the U.S. are employed or are family members of someone who works. In several studies this type of plan has garnered a marginally greater measure of public support (5–10 percent) than an entirely government financed insurance system. In surveys conducted by a number of different organizations, 74–82 percent of Americans supported this type of proposal in 1989 and 1990.

THE PUBLIC-PRIVATE CONTROVERSY

One problem with many of the surveys conducted on the preferred restructuring of the system is that pollsters do not often give the public both major options in one question in order to see which is preferable. As a result we are left with a large degree of support for each option and little sense of whether people are willing to make a choice, a controversial decision that is at the heart of making policy on this issue. Polls conducted by Louis Harris during the national health insurance debate in the 1970s showed that the public, when offered both options, was split over the choice between creating a new public system or modifying our current private-public system to expand insurance through employer requirements. Harris agreed to repeat this question in 1990 and found that there had been a slight shift in which option was supported by the plurality, but there was still no majority consensus. As noted earlier, if supporters of change are divided about the form that change should take, the will of the minority that wants no change could prevail.

SATISFACTION WITH HEALTH SERVICES VS. HEALTH CARE SYSTEM

What is sometimes perplexing about public attitudes toward the U.S, health care system is that the intense level of support for change in the system is not accompanied by dissatisfaction with personal health care services. In fact, the vast majority of Americans who use the health care system are generally very happy with those services. In a 1990 Gallup survey for the American Medical Association, 85 percent say they were very or somewhat satisfied with their most recent physician visit; in another survey, 88 percent were satisfied with the quality of their physician care and 76 percent with the quality of their hospital care.

What do these data mean when viewed in light of the public's dissatisfaction with the system as a whole? The public wants to maintain its existing health care arrangements, but they want the services they use to cost less and they want to be sure they will have insurance in the event of a serious illness.

This conclusion is supported by a responses to a number of surveys in which the Americans indicate that they favor cost-control policies that would regulate hospital charges and physician fees, regionalize expensive medical technologies and reduce unnecessary hospitalizations, tests and procedures. However, they are not happy with proposals to limit choice of health care providers (as in health maintenance organizations), or limit care to the elderly or terminally ill purely as a cost-savings measure (There is considerable public support as a quality of life measure for allowing individuals and their families to refuse life-support measures when they are terminally ill, however).

WILL THE PUBLIC BE WILLING TO PAY FOR HEALTH CARE REFORM?

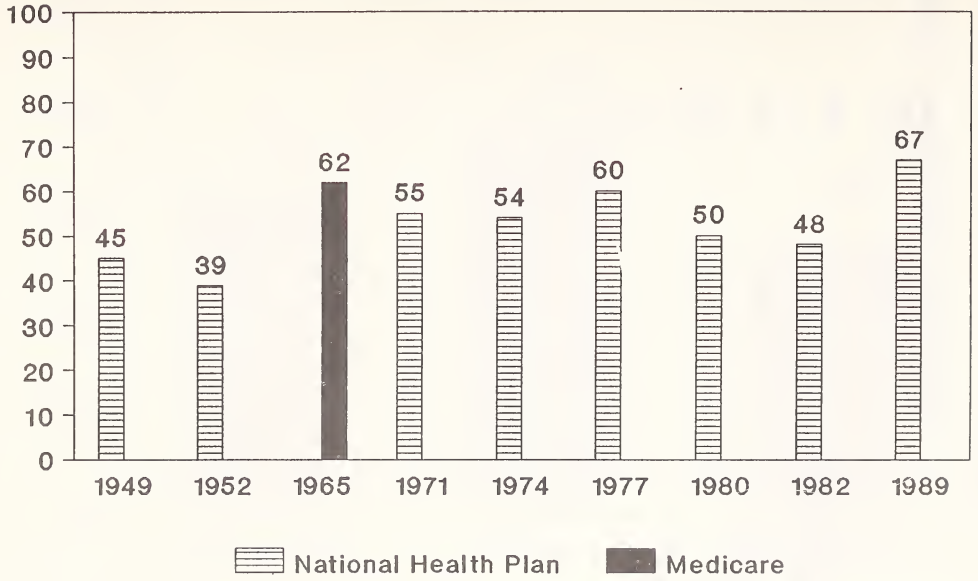
Three surveys undertaken between 1988 and 1990 show that the level of public support for the adoption of a national health insurance plan declines in proportion to the increase in taxes proposed to fund it. Americans will express support for this program if it entails a modest increase in their tax burden. The *Los Angeles Times* reported in 1990 that 72 percent would support a national plan even if it entailed a tax increase. However, only 22 percent would be willing to pay more than $200/year to see this happen, and 33 percent remain undecided. Harris surveys have demonstrated that the most popular source of revenues to fund a universal health program are, in descending order, increases in taxes on cigarettes and liquor; social security taxes paid by employers for each employee; insurance premiums paid by the individual; and income taxes. Other surveys suggest support for an earmarked health-related sales tax.

POSSIBILITIES FOR SHAPING A CONSENSUS

Despite the high level of public interest in finding a solution to the nation's health care problems, there is as yet no agreement about what type of plan would be acceptable to Americans. Based on our analysis, we believe that five guidelines should be followed in the design of new national health insurance proposals if a public consensus is to be achieved: (1) Any new proposal should not try to resolve the dispute over whether the method of financing the system should be entirely public or private. Instead, it should contain elements of both. (2) Cost-containment proposals should not require dramatic changes in individual medical arrangements, but rather should focus on hospitals, doctors and insurers. (3) Years of opinion polling have suggested that health programs for poor children are supported by the public, welfare programs are not. As a result, the Medicaid programmed has suffered by its identification with public assistance programs. Therefore, the adminis-

tration of the Medicaid program should be transferred to a locus outside the welfare system where it can be more readily identified as a health program. (4) Any new program should rely on taxes other than the progressive income tax for its principle method of funding, and revenues should be placed in a fund earmarked for this program. Given the current perceptions of wasted money in health care and other sectors of government, some of the resources for a program of universal health care should come from reallocation of funds already spent within the health system or other government programs. (5) Phase in any new program, and therefore the program's costs, over a period of years so as to blunt the impact on the taxpayer.

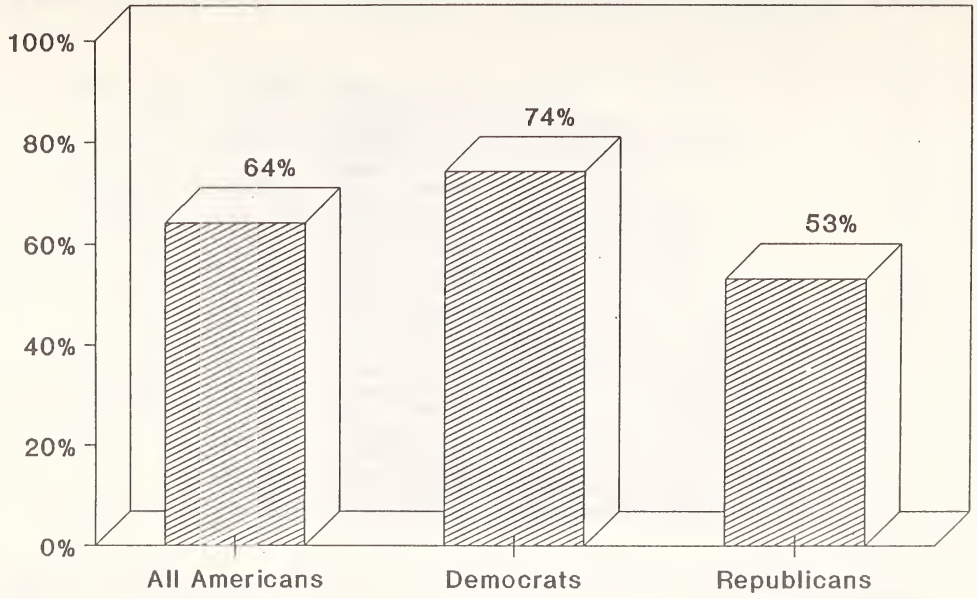
Support for a National Health Plan That Is Totally Government Financed



American's Preferences for Canadian System

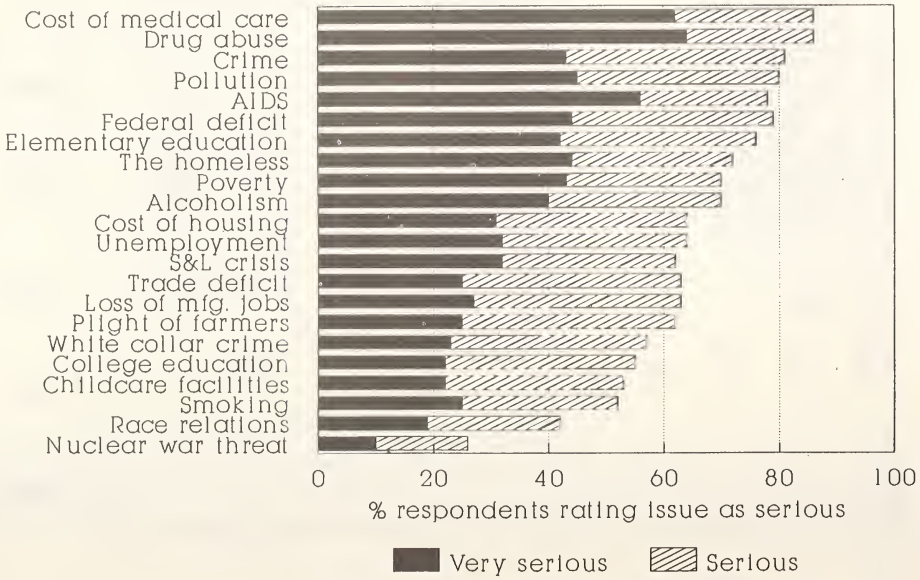
	Harvard/Harris (1988)	HIAA-Roper (1989)	Los Angeles Times (1990)
Prefer Canadian System	61%	45%	66%
Prefer Our System	37%	37%	25%
Don't Know/No Answer	2%	18%	9%

Favor National Health Insurance Financed By Taxes



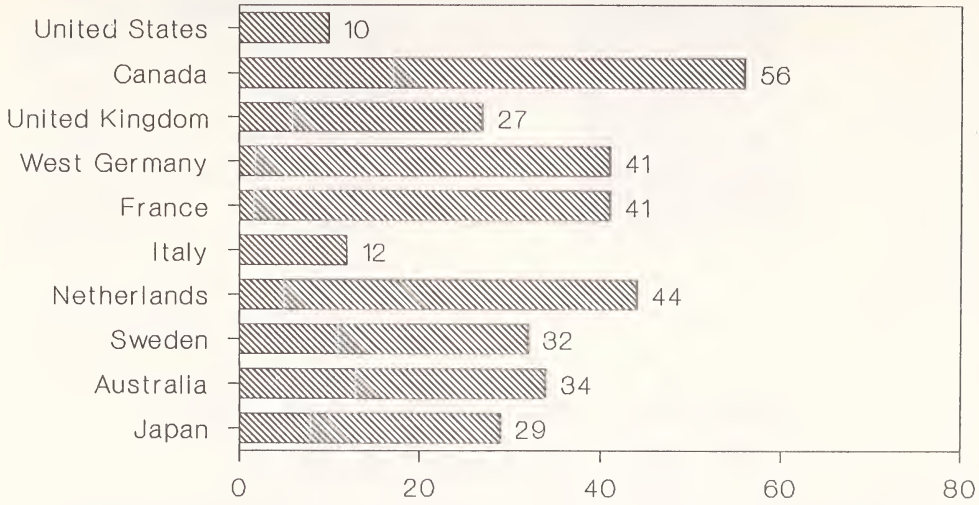
Source: The New York Times

Here are a number of economic and social issues that are causing many people concern. How would you rate the seriousness of each?

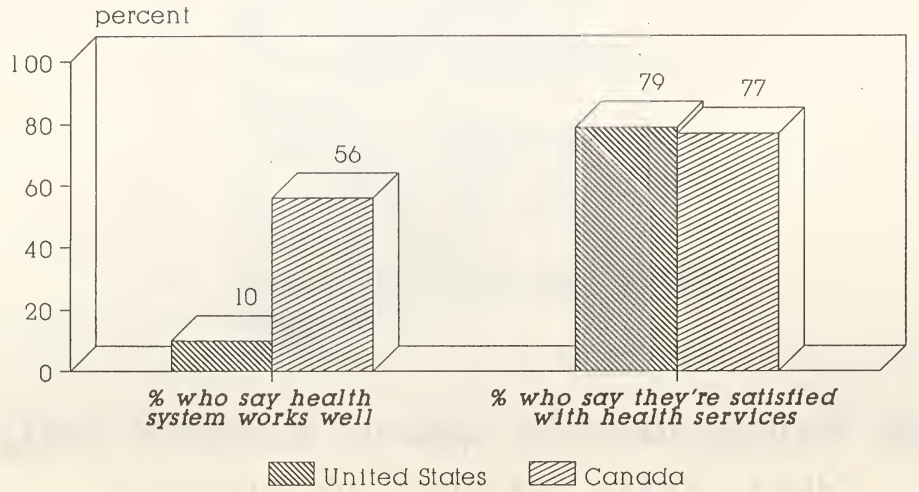


43-866 O - 91 - 5

Percent of Citizens Who Think Their Nation's Health System Works Well

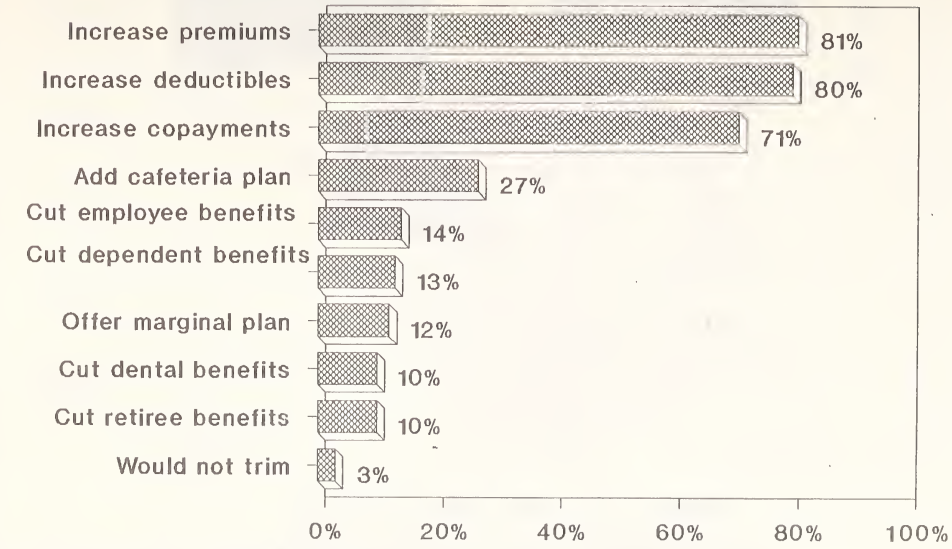


SATISFACTION WITH HEALTH SYSTEMS AND SERVICES, 1988-89
United States and Canada

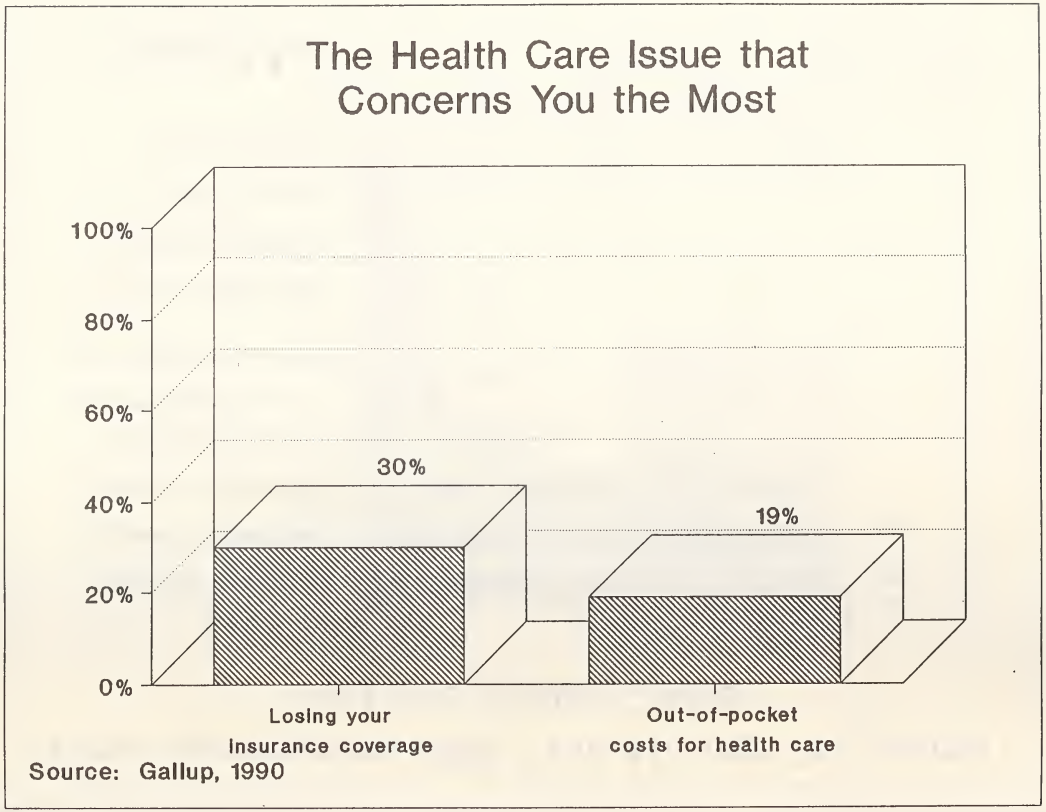


Louis Harris and Assoc, Gallup Canada

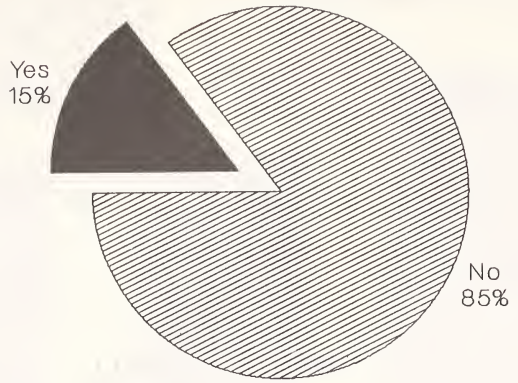
How Companies Will Trim Health Programs To Hold Down Costs



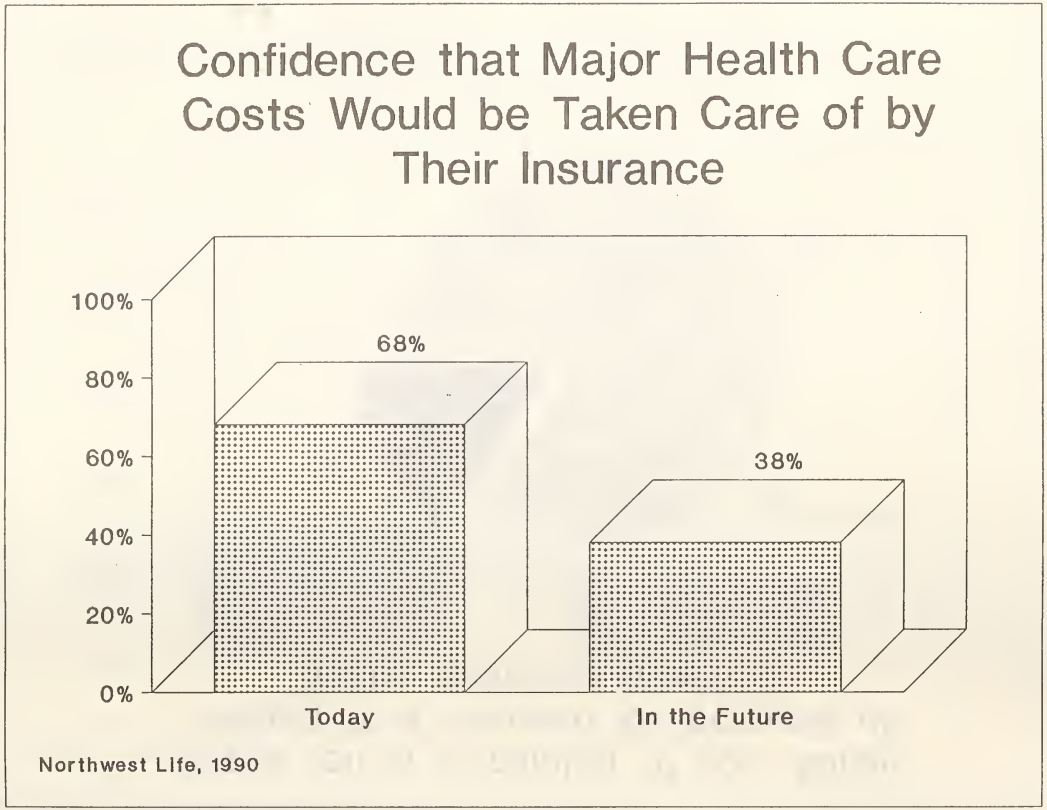
Source: Business and Health, 1990


The Health Care Issue that Concerns You the Most
100%
80%
60%
40%
20%
0%
30%
19%
Losing your insurance coverage
Out-of-pocket costs for health care
Source: Gallup, 1990

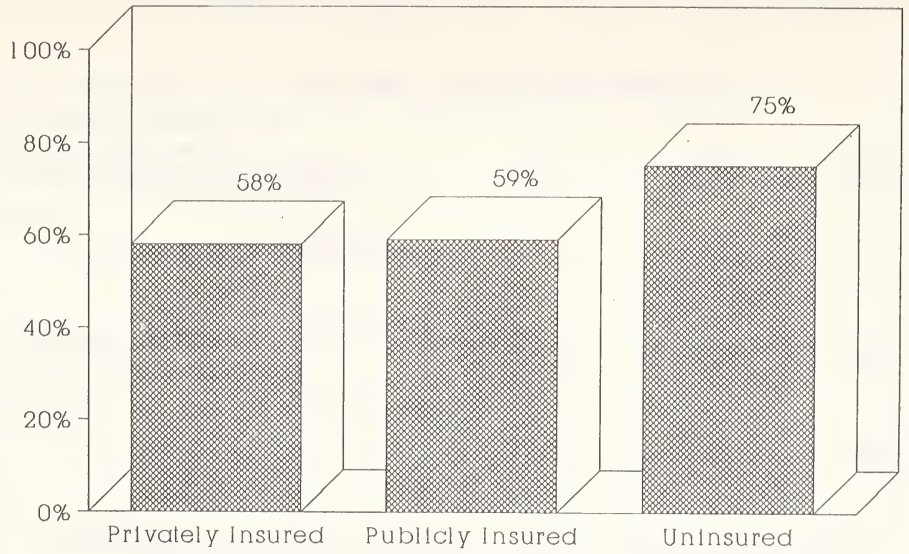
Have you or a member of your family stayed in or changed job because of health insurance benefits?



Source: Associated Press, 1991


Confidence that Major Health Care Costs Would be Taken Care of by Their Insurance
100%
80%
60%
40%
20%
0%
68%
38%
Today
In the Future
Northwest Life, 1990

Lack of Confidence that Insurance Will Cover Future Major Health Care Costs



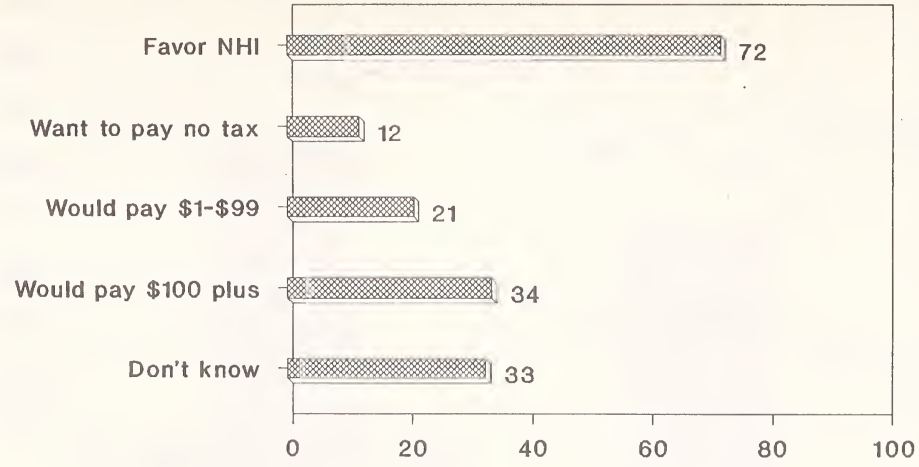
Northwest Life, 1990

Americans' Preferences for Universal Health Insurance System Options, 1972, 1976, and 1990

	1972	1976	1990
Option I: Favor an all government national health plan	22%	27%	46%
Option II: Favor a compulsory private insurance plan with government providing for the unemployed	40%	38%	33%
Option III: Favor no change in present system	30%	27%	19%

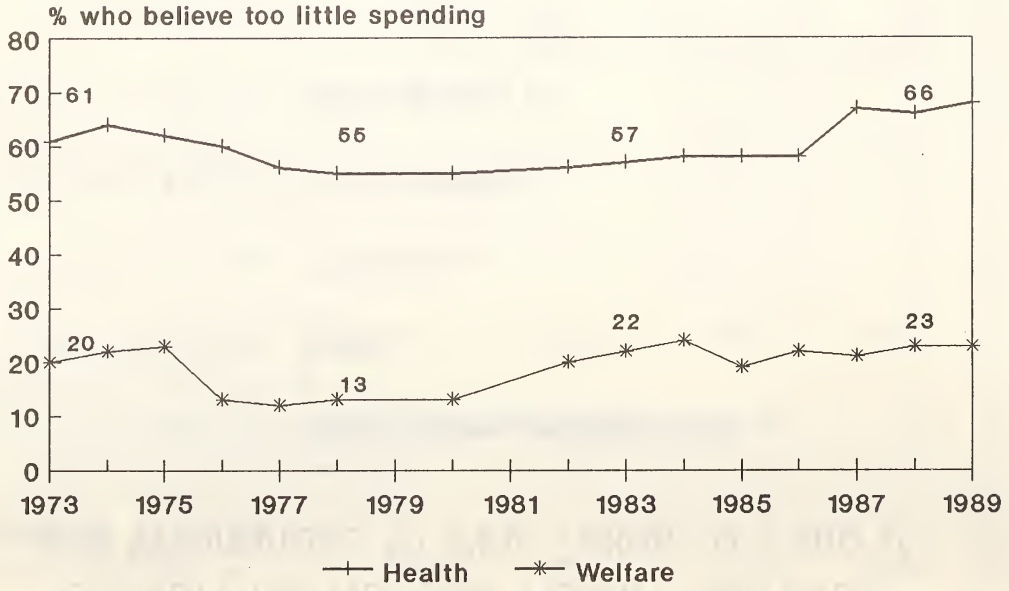
Source: Louis Harris and Associates, Inc.

Support for National Health Insurance and Willingness to Pay Taxes to Fund It

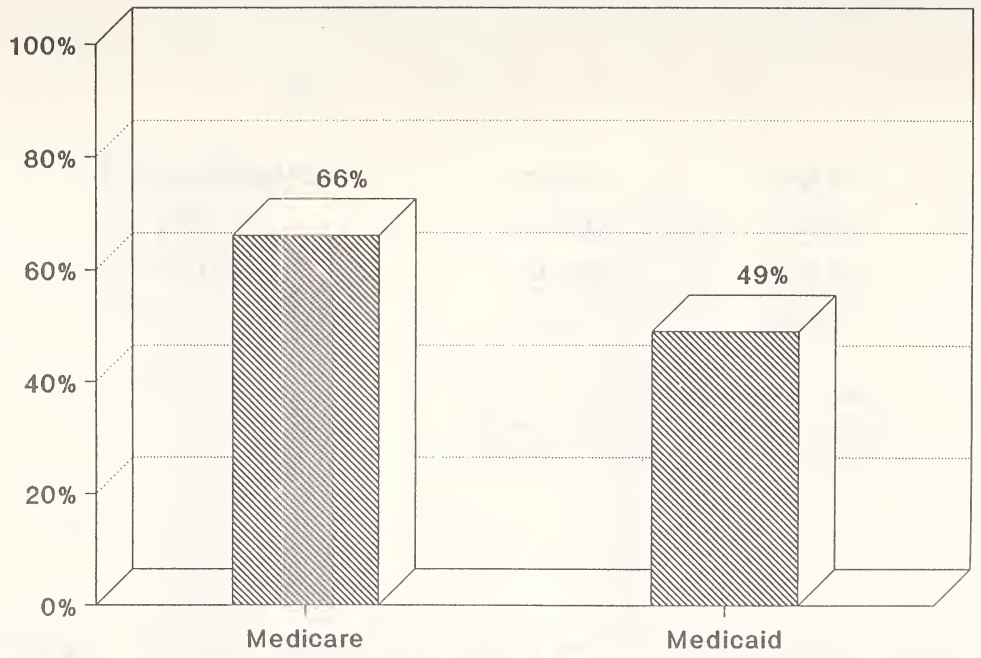


Source: Los Angeles Times, 1990

The Public's View of Spending on Health and Welfare



Public Support for Increased Spending



Source: National Opinion Research Center

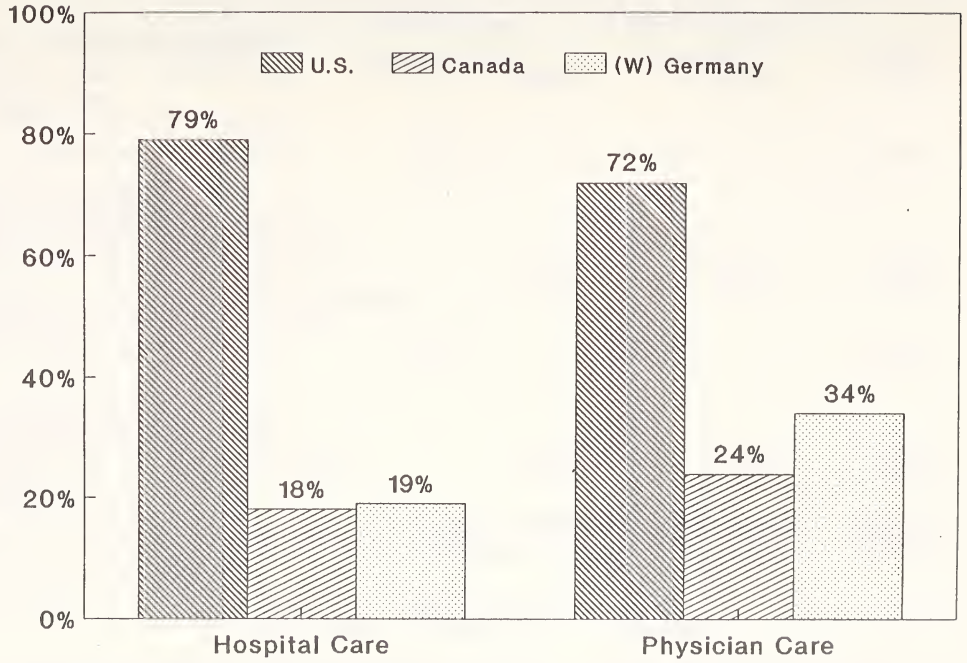
Public Satisfaction in Four Nations With Health Care System and Own Medical Care

Country	*Satisfied with Current Health Care System**	*Very Satisfied With Own and Family's Care*
U.S.	10%	55%
Canada	56%	60%
Britain	27%	39%
(W) Germany	41%	45%

*only minor changes needed

Source: Harvard/Harris. HCHP/Harris

Is Your Nation Spending Too Much?



Source: Harvard Community Health Plan

Preferences for Universal Health Insurance System Options, 1990

	Corporate Executives	*Union Leaders*	*Public*
Option I: Favor an all government national health plan	27%	58%	46%
Option II: Favor a compulsory private insurance plan with government providing for the unemployed	35%	28%	33%
Option III: Favor no change in the present system	35%	10%	19%

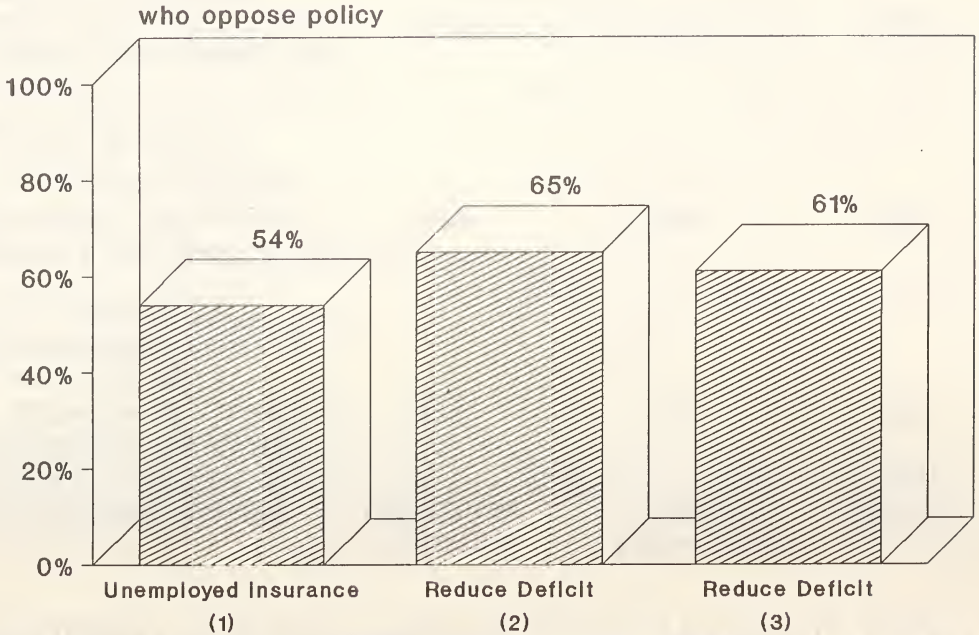
Source: Louis Harris and Associates, Inc.

Attitudes Toward Health Care Reform, 1990

	Corporate Executives	Labor Union Leaders	Public
On the whole, the health care system works pretty well, and only minor changes are necessary to make it work better	*12%*	*0%*	*16%*
There are some good things in our health care system, but fundamental changes are needed to make it work better	*63%*	*30%*	*59%*
The health care system has so much wrong with it that we need to completely rebuild it.	*25%*	*70%*	*24%*

Source: Louis Harris and Associates

Taxing Employer Provided Health Insurance Exceeding a Certain Amount



(1)Louis Harris (1983) (2)Opinion Research Corp.(1984) (3)Louis Harris (1985)

Prepared Statement of Senator John H. Chafee

[April 16, 1991]

Mr. Chairman, I commend you for convening today's hearing. We are facing a crisis in our health care system. There are over thirty million uninsured individuals in this nation who have limited access to critical health care services. We are spending a greater percentage of our GNP on health care than any other industrialized nation, yet we fall behind them in key health indicators such as infant mortality and life expectancy.

Today, we will hear testimony from some impressive leaders of the business community. As I am sure they will tell us, it is becoming increasingly expensive and difficult to provide health insurance coverage to their workforce. According to a *New York Times* article, 26% of the average company's net earnings are spent on medical care. This is severely affecting the ability of our businesses to compete in the international marketplace.

In my home state of Rhode Island, there are an estimated 68 thousand individuals without health insurance. The number is rising as employers are forced to lay-off workers due to the economic crisis in the state. In addition, Rhode Island faces a projected deficit of $220 million and is considering reductions in programs such as Medicaid and childhood immunizations which help low-income individuals.

Rhode Island, has made a significant investment in ensuring that its residents have access to health care services. Not only has the state adopted virtually every option under the Medicaid program, but it has provided services to those not eligible for the program.

I believe that Congress needs to develop and enact a comprehensive health care reform bill. In developing a proposal we must ensure that all American have access to appropriate health care services (not necessarily health insurance), and we must assure that we are getting the best value for our health care dollar.

Many of us on the Finance Committee have been wrestling with this difficult issue for some time. I have been working with my colleagues through the Republican Task Force on Access to Health Care, which I chair, as well as with Mr. Riegle and others through the Bi-Partisan Working Group.

I, of course, have certain ideas about how to reform our health care system, as I am sure do most members of this Committee. In working toward enactment of health care reform, there are several key factors which must be taken into consideration.

First, every aspect of our society plays a role and has certain responsibilities in the delivery of health care. *Employers* should be encouraged to *provide cost-effective health insurance to their employees.* Federal, state and local governments should bear a certain responsibility to assist those who are low-income and without access to health care services. Providers should be encouraged to provide the most cost-efficient and appropriate services.

And perhaps most importantly, individuals must realize that they are responsible for their own well-being. I look forward to hearing the testimony of the Consumers Union in how they feel individuals can make changes in their lifestyles and to ensure better health such as diet, regular exercise, and smoking cessation. In addition, I believe that individuals should be made aware of the cost of health care services and should purchase insurance coverage if it is available and affordable.

Second, we must acknowledge, that different areas and populations have different problems in assuring access to health care services. Policies that make sense in rural Iowa or West Virginia, may be ineffective in Providence, RI. We must allow States and communities flexibility in determining how to best deliver health care services within their particular jurisdictions.

I look forward to this and subsequent hearings, and to working with my colleagues in developing a health care reform package. Thank you Mr. Chairman.

Prepared Statement of Richard Darman

INTRODUCTION

Chairman Bentsen, Ranking Republican Senator Packwood, and members of the Committee:

Thank you for inviting me to testify. It is, as always, a pleasure to have an opportunity to appear before the distinguished Senate Finance Committee.

This is the first opportunity I have had to appear before the Committee since the recent, sudden, and highly regrettable loss of Senator John Heinz. I know how much you miss your colleague. I hope you may appreciate that I feel I cannot and should not begin without noting that Senator Heinz will be missed deeply and long by those of us who may appear before you on this side of the table.

It was my privilege to have known and worked with Senator Heinz for over twenty years. With me, as with so many others, he was always conscientious, well-informed, hard-working, independent-minded, thoughtful, fair, public-spirited, and kind. Like you, I will long be grateful for Senator Heinz's extraordinary contributions to the public interest. And with words far short of my feelings, I ask simply that you accept this brief expression of appreciation and respect.

* * *

Your letter of invitation, Mr. Chairman, asks that I discuss rising health expenditures, along with the related issues of cost control and access to health insurance. I would propose to do so by offering a series of ten simple observations—supported by straightforward charts.

The relative simplicity of these observations should not be misleading, however. These are *simple* observations about an extraordinarily *complex* problem. They do not point to a clear and simple solution. I doubt that there is such a clear and simple solution. Nonetheless, I hope these observations may be helpful in providing perspective for the important work of this Committee.

TEN SIMPLE OBSERVATIONS ABOUT AN EXTRAORDINARILY COMPLEX SUBJECT

SIMPLE OBSERVATION NUMBER (1):

The growth of federal expenditures for health is part—an increasingly important part—of a more general budgetary problem: the explosion of "mandatory" programs.

"Mandatory" programs are not subject to annual appropriation by the Congress. Once established, they spend—and typically grow—automatically. They have been steadily taking over the federal budget. (See charts 1 and 2.)

"Mandatories" include "entitlement" programs that grow automatically with population or demand for services. "Entitlements" also typically grow with automatic upward adjustments for inflation. In some cases (as with health) the upward adjusting mechanisms are tied to indexes that are greater than the general inflation rate. In all cases, such indexes can contribute either directly to further inflation, or indirectly to a weakening of the political will to limit inflation. Further, the eligible class of beneficiaries is often very broad. This renders such entitlements inefficient as anti-poverty programs. But the very eligibility breadth that thus renders them inefficient makes them politically attractive for further expansion—and highly unattractive for restraint. This has effectively become a *generic problem* for a wide range of "entitlement" programs.

Beyond "entitlements", "mandatory" programs also include subsidies that range from certain specialized credit programs to deposit insurance for a limitless number of hundred-thousand-dollar accounts. In my first Introduction to the President's Budget, I highlighted these "mandatory" programs and other hidden liabilities. I referred to them as "hidden PACMEN . . . each waiting to spring forward and consume another line of resource dots in the budget maze." At that time, I put "rising costs of health care" high on the list of hidden PACMEN. But I tried to emphasize then—as I again try to emphasize now—that the budgeting problem is broader than any particular case.

In the past two years, we have made significant progress in improving the government's ability to account for hidden PACMEN. But until the Congress develops an effective means to subject the *full range* of mandatory programs to systematic budgetary discipline and reform—above and beyond the valuable recent advances of credit reform and pay-as-you-go—cost control in one area is likely to be offset by further expansions in other areas.

Put another way: *The basic budgetary problem is not addressed by focusing on health costs alone.*

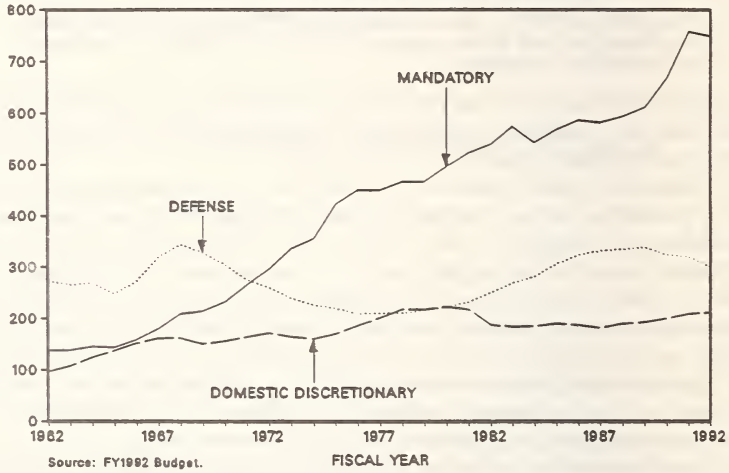
That said, it is noteworthy with regard to health that:

(a) *Health outlays have become a highly significant portion of the exploding mandatory total.* (See charts 3 and 4.)

(b) Indeed, *health entitlements will soon surpass Social Security* as the single largest component of mandatory spending. (See chart 5.)

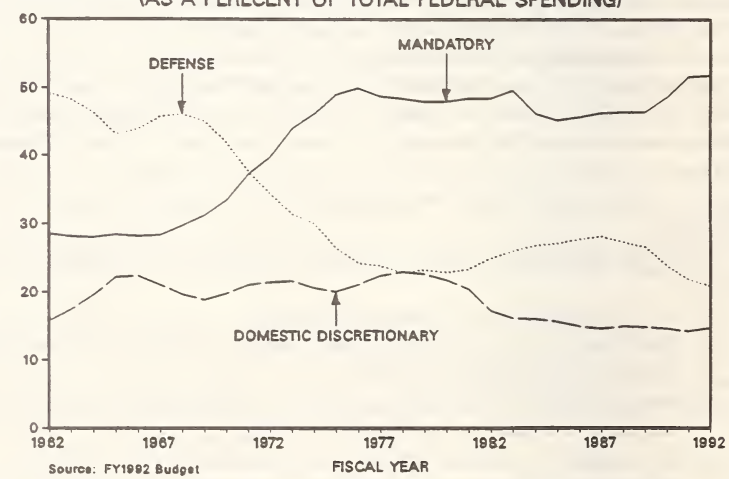
(c) The problem of exploding federal health expenditures is *exclusively in the "mandatory" programs—not* in the discretionary health programs. (See chart 6.)

CHART 1
"MANDATORY" PROGRAMS ARE TAKING OVER THE BUDGET
(OUTLAYS, IN BILLIONS OF 1992 DOLLARS)



Source: FY1992 Budget.

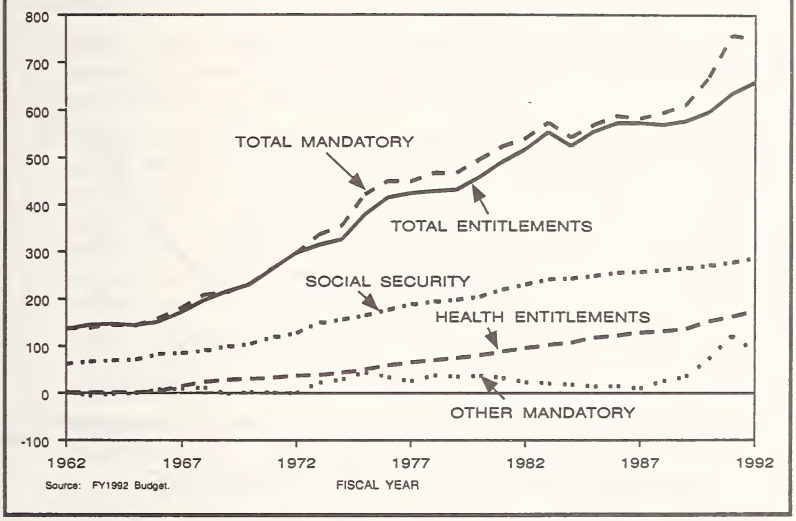
CHART 2
"MANDATORY" PROGRAMS ARE TAKING OVER THE BUDGET
(AS A PERECENT OF TOTAL FEDERAL SPENDING)



Source: FY1992 Budget

CHART 3. OUTLAYS FOR MANDATORY PROGRAMS

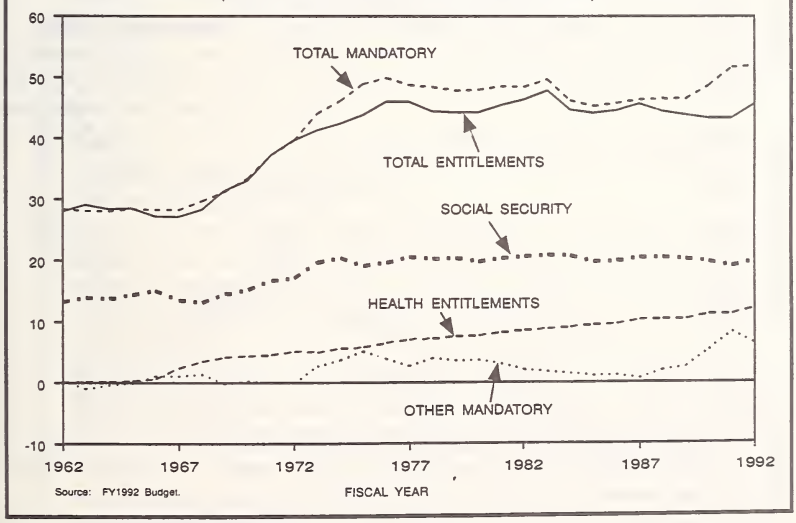
(IN BILLIONS OF 1992 DOLLARS)



Source: FY1992 Budget.

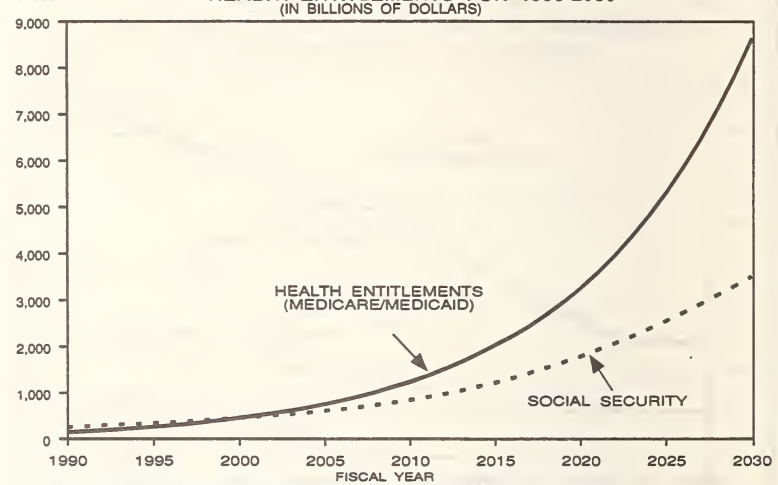
CHART 4. OUTLAYS FOR MANDATORY PROGRAMS

(AS A PERCENT OF TOTAL FEDERAL SPENDING)



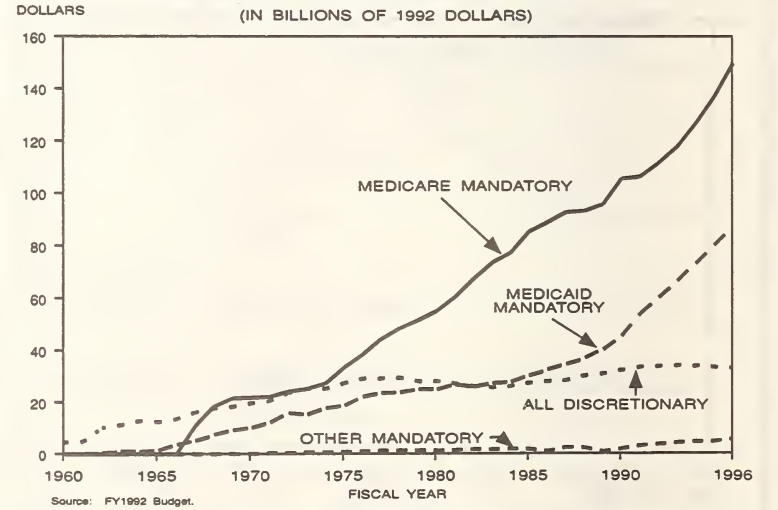
Source: FY1992 Budget.

CHART 5. PROJECTED SOCIAL SECURITY AND HEALTH ENTITLEMENTS FOR 1990-2030
(IN BILLIONS OF DOLLARS)



Note: Medicaid payments projection based on 1985-1990 compound annual growth rate of 12.7% per year.
Sources: Social Security Trust Fund Trustee's Report, 1990; and Health Care Financing Administration, Office of the Actuary, December, 1990.

CHART 6. MANDATORY AND DISCRETIONARY FEDERAL OUTLAYS FOR HEALTH
(IN BILLIONS OF 1992 DOLLARS)



Source: FY1992 Budget.

SIMPLE OBSERVATION NUMBER (2):

Health expenditures are rising at a rate that is not only high, but also unsustainable.

(a) Federal health outlays are *growing rapidly by virtually all measures*—as a percent of all federal outlays; as a percent of all outlays except Social Security and interest; and as a percent of GNP. (See chart 7.)

(b) Medicare Part B is now about 3 percent of the federal budget. But it alone is on a growth path that could exceed 12 percent of the federal budget by 2030 (assuming continuation of a 25 percent beneficiary premium contribution). It would be still higher if the beneficiary premium growth were limited. The combination of Medicare Parts A and B is now about 7 percent of the federal budget. Medicare is projected to exceed 30 percent of the federal budget by 2025 (assuming the federal budget is at 20 percent of GNP). This means that to support current Medicare projections alone, either the federal budget would have to grow far beyond 20 percent of GNP *or the rest of the budget would have to decline by more than 20 percent in real terms—in order to make room for Medicare.* (See chart 8.)

(c) Total public and private health spending is on a growth path that would take over the Gross National Product—if that were not a *practical impossibility.* Total health spending has grown from less than 6 percent of GNP three decades ago to about 12 percent today. It is currently projected to reach 17 percent by the year 2000 and 37 percent of GNP by 2030. If, after the year 2000, projected health spending grew only for demographic reasons—but not for excess health inflation—it would still exceed 20 percent of GNP by 2030. (See chart 9.)

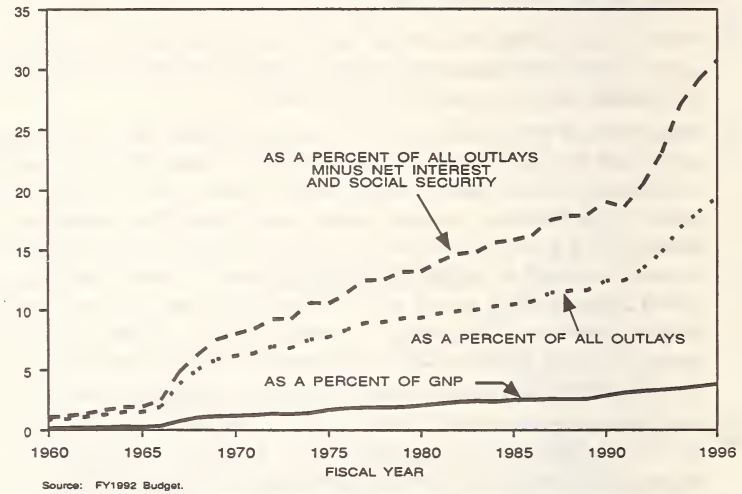
Even if it were possible to imagine a GNP and a federal budget that were each over 30 percent health—which is difficult—it is even more difficult to see how such levels would be satisfactorily financed. *Individuals* are already complaining that they are overburdened with health costs. And:

(d) *Business* spending on health premiums has already risen substantially as a percent of compensation and wages—and is now in excess of 100 percent of after-tax profits. (See chart 10.)

(e) Just to close the currently projected Medicare fiscal financing gap (for the year 2035) has been estimated to require the equivalent of *an additional 6 percent of OASDI payroll under intermediate economic assumptions (and 16 percent of OASDI payroll under more pessimistic assumptions).* Putting aside whether this is desirable (which it is not), *it does not even seem plausible.* (See chart 11.)

NOTE: This would be even less plausible if combined with the topical proposal to abandon the bipartisan Social Security agreement and adopt current-cost-financing for Social Security. Such a proposal would require a major Social Security tax increase in the future (and is strongly opposed by the Administration). *The combination of hypothetical large increases in both Social Security and Medicare taxes is surely prohibitive.*

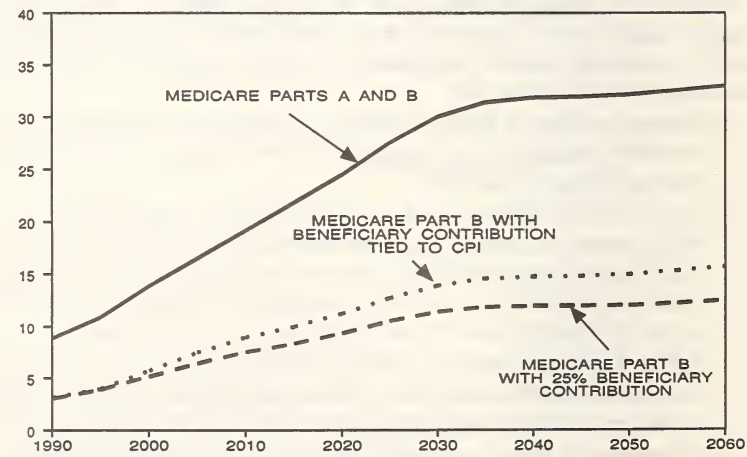
CHART 7. FEDERAL HEALTH OUTLAYS ARE GROWING RAPIDLY -- BY SEVERAL MEASURES



Source: FY1992 Budget.

CHART 8. MEDICARE IS PROJECTED TO TAKE MORE AND MORE OF THE BUDGET

(PERCENT OF PROJECTED FEDERAL BUDGET)



Note: Assumes Federal Budget stays at 20% of GNP.
Source: Health Care Financing Administration, Office of the Actuary.

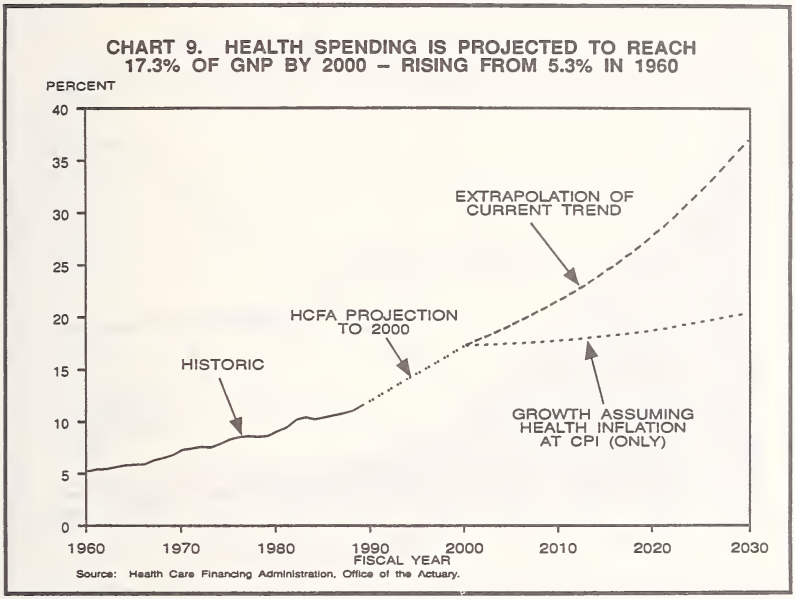


CHART 9. HEALTH SPENDING IS PROJECTED TO REACH
17.3% OF GNP BY 2000 – RISING FROM 5.3% IN 1960
PERCENT
40
35
30
25
20
15
10
5
0
EXTRAPOLATION OF
CURRENT TREND
HCFA PROJECTION
TO 2000
HISTORIC
GROWTH ASSUMING
HEALTH INFLATION
AT CPI (ONLY)
1960
1970
1980
1990
2000
2010
2020
2030
FISCAL YEAR
Source: Health Care Financing Administration, Office of the Actuary.

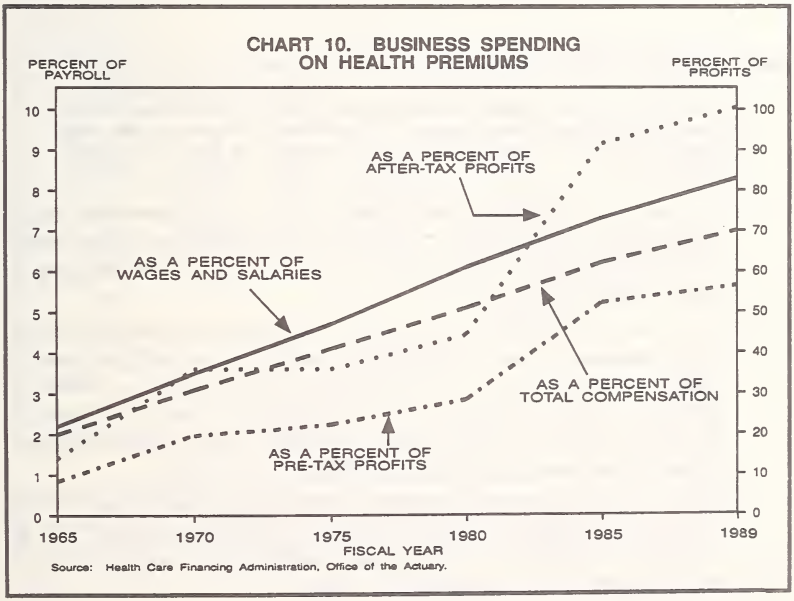
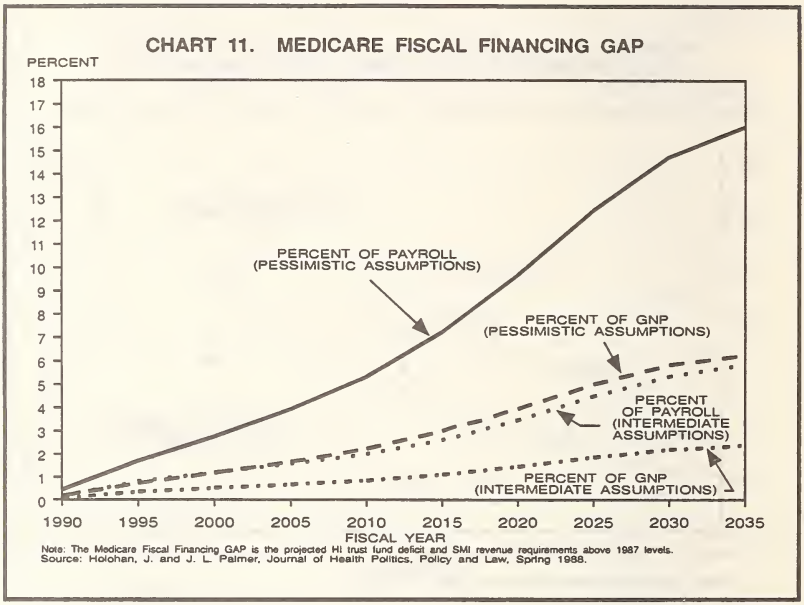


CHART 10. BUSINESS SPENDING
ON HEALTH PREMIUMS
PERCENT OF
PAYROLL
PERCENT OF
PROFITS
10
9
8
7
6
5
4
3
2
1
0
100
90
80
70
60
50
40
30
20
10
0
AS A PERCENT OF
AFTER-TAX PROFITS
AS A PERCENT OF
WAGES AND SALARIES
AS A PERCENT OF
TOTAL COMPENSATION
AS A PERCENT OF
PRE-TAX PROFITS
1965
1970
1975
1980
1985
1989
FISCAL YEAR
Source: Health Care Financing Administration, Office of the Actuary.



SIMPLE OBSERVATION NUMBER (3):

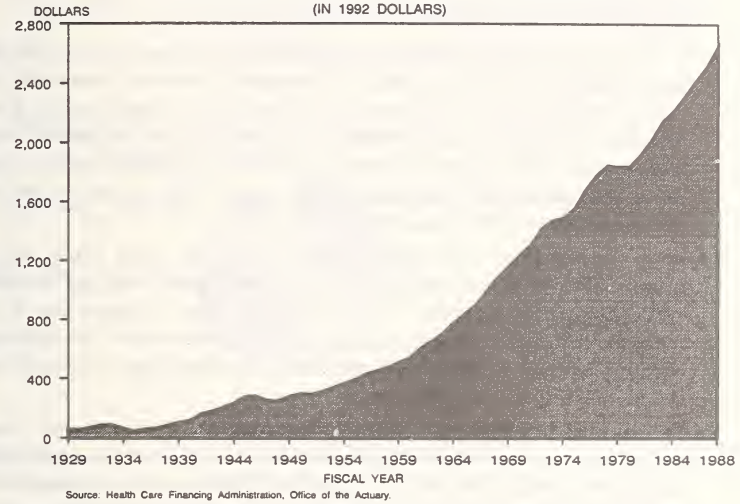
Although real per capita health expenditures have been rising dramatically, there are reasons to be disturbed about both the adequacy and the distribution of the return on this increasing investment.

(a) Real per capita health expenditures have not only risen dramatically in the United States (See chart 12). They have also *far out-paced the per capita expenditures of all other OECD countries*—even when adjusted for differences in per capita GDP. (See chart 13.)

(b) *Yet, by several measures, U.S. health status is not conspicuously superior;* and by some measures, it is clearly inferior. Our neighbor to the north, for example, spends a fraction of what we do on health per capita and as a percent of GNP—but nonetheless enjoys lower infant mortality rates, lower maternal mortality rates, lower mortality rates for low-risk and moderate-risk surgery, and higher life expectancy for both men and women.

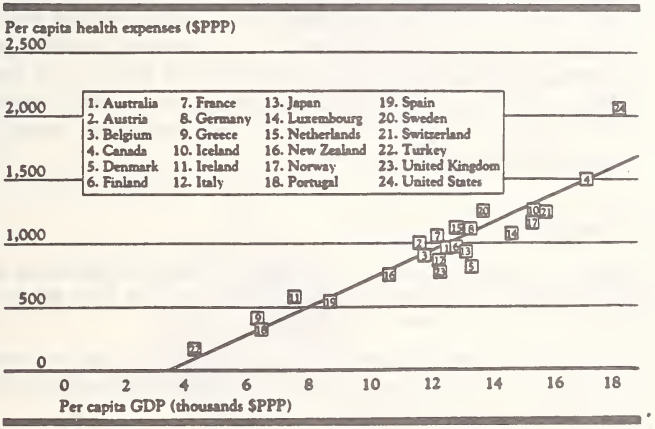
(c) *Further,* there is the much-noted problem of *uneven access* to health insurance and health care. Roughly 13 percent of Americans have been estimated to be completely *uninsured*—and as many as 28 percent may be uninsured for one month or more. (This is discussed further below.)

CHART 12. REAL PER CAPITA NATIONAL HEALTH EXPENDITURES



Source: Health Care Financing Administration, Office of the Actuary.

Chart 13. Health and Wealth In OECD Countries, 1987



Source: Exhibit 4 in Schieber, et al., *Health Affairs*, Page 173 (Fall 1989).
Note: PPP = purchasing power parity. PCH=per capita health spending. PCGDP = per capita gross domestic product. PCH = -363 + 0.105 × PCGDP. Both the constant term and the regression coefficient are statistically significant at the .01 level. R^2 = .86 (adjusted correlation coefficient squared).

SIMPLE OBSERVATION NUMBER (4):

The problem of "the uninsured" is not quite as simple—in either its incidence or its effect—as some may naturally think.

(a) For the uninsured who are poor and unemployed, the problem is serious. But the general problem of "the uninsured" is *not principally a problem of those below the poverty level.* 70 percent of the uninsured are above the poverty level. *It is not principally a problem of the permanently unemployed.* Only 25 percent of the uninsured are out of work for a full year. And it is *not principally a problem of the young.* Only 26 percent of the uninsured are under 18; 54 percent are between the ages of 25 and 64. (See chart 14.)

(b) *Being "uninsured" does not mean that one is unable to receive health care.* It means, rather, that one is more likely to use emergency room care and less likely to use office, clinic, or regular inpatient care. This is not to suggest that this is desirable. It is not. (Reliance on emergency care can be harmful for the individual and more costly for society.) The intent is simply to clarify that "uninsured" does not mean totally unable to receive care.

(c) Because much care is in fact provided to the uninsured, and because only about half of this care is paid for out-of-pocket by the uninsured, there is a substantial residual cost that is, in a sense, "uncompensated." Such costs can be thought of as covered by subsidies of one sort or another. For example, insured employees are charged more to cover "uncompensated" costs of the uninsured. And hospitals may be thought of as covering "uncompensated" care through "disproportionate share" hospital payments, through tax subsidies for hospital finance, charitable contributions, and non-profit treatment, etc. A corollary of this point is that increased coverage of the uninsured does not necessarily translate into *fully proportional* increases in *system-wide* costs. Part of what may be involved is shifting the incidence of the burden (although there are obviously, also, increases to be expected from greater utilization). This complication makes efficient targeting of remedies difficult.

SIMPLE OBSERVATION NUMBER (5):

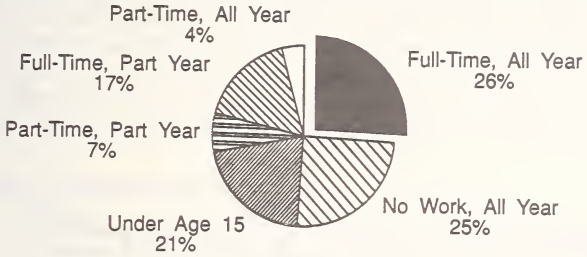
Although one might think that the massive federal expenditures for health should go substantially to the poor, in fact they go overwhelmingly to the non-poor.

(a) For fiscal year 1992, total federal health expenditures (tax and outlay) are estimated at over $250 billion—of which only $53 billion (21 percent) is estimated to go to the poor. (See chart 15.)

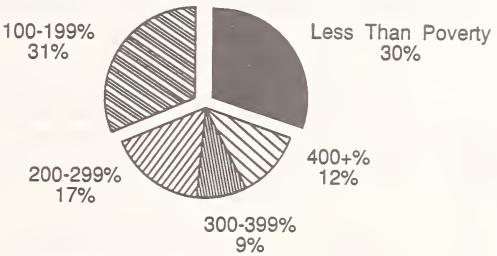
(b) While less than half of Medicaid expenditures go to people above poverty, *almost 90 percent of Medicare expenditures go to people above the poverty level.* And *almost 100 percent of tax expenditures* for employer-provided health plans go to people above the poverty line. (See chart 16.)

CHART 14. DISTRIBUTION OF UNINSURED
(PERCENT OF UNINSURED)

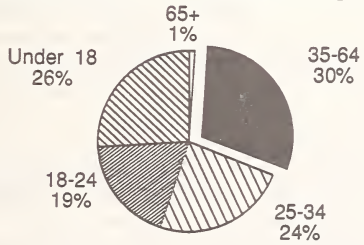
UNINSURED IN RELATION TO WORK STATUS



UNINSURED IN RELATION TO INCOME STATUS
(INCOME AS A PERCENT OF POVERTY)

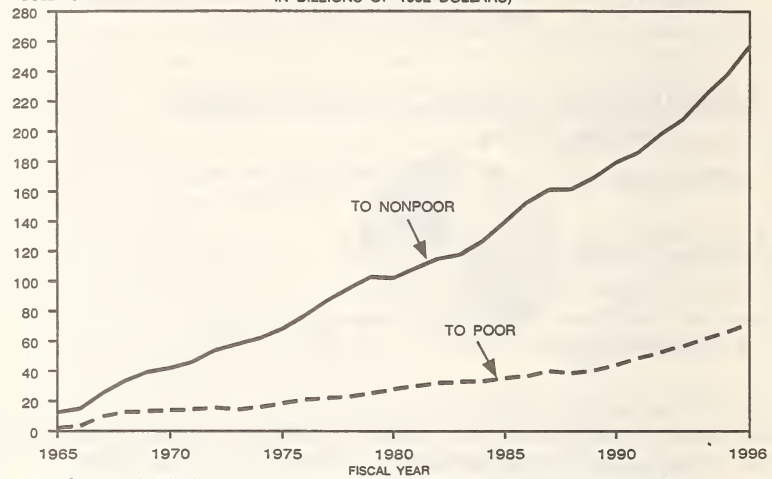


UNINSURED IN RELATION TO AGE



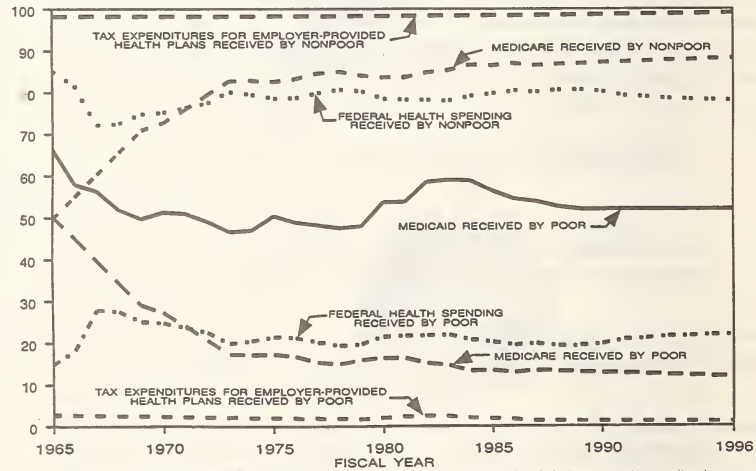
Source: CPS data for 1988.

CHART 15. FEDERAL HEALTH SPENDING
(OUTLAYS AND TAX EXPENDITURES, IN BILLIONS OF 1992 DOLLARS)



Includes: Federal spending for Medicare, Medicaid, hospital and medical care for veterans, and other payments to individuals for health purposes; and tax expenditures for employer-provided health plans and for deductions of health expenses. Spending share to poor reflects percent of recipients with money incomes below poverty thresholds.
Sources: FY1992 Budget and various Census Bureau publications on receipt of noncash benefits.

CHART 16. PERCENT OF FEDERAL HEALTH SPENDING BENEFITTING POOR VS. NONPOOR



Includes: Federal spending for Medicare, Medicaid, hospital and medical care for veterans, and other payments to individuals for health purposes; and tax expenditures for employer-provided health plans and for deductions of health expenses. Spending share to poor reflects percent of recipients with money incomes below poverty thresholds.
Sources: FY1992 Budget and various Census Bureau publications on receipt of noncash benefits.

SIMPLE OBSERVATION NUMBER (6):

Reducing public subsidies for the non-poor can help free limited public funds for other purposes (including expanded health benefits for the poor or the uninsured near-poor)—but this is a matter of public budgeting and equity, not system-wide cost control.

Because the projected future levels of federal health expenditures are not sustainable (as noted above), the political system is likely to be driven toward reduction of subsidies for the non-poor. (A start in this direction is proposed in the President's budget.) But from a system-wide perspective, budgetary savings from subsidy reduction would be largely offset by a shift of the payment burden to currently-subsidized, non-poor, private individuals. And if the budgetary "savings" were spent on increased health benefits for the poor, equity might be improved, but system-wide health expenditures would go up.

SIMPLE OBSERVATION NUMBER (7):

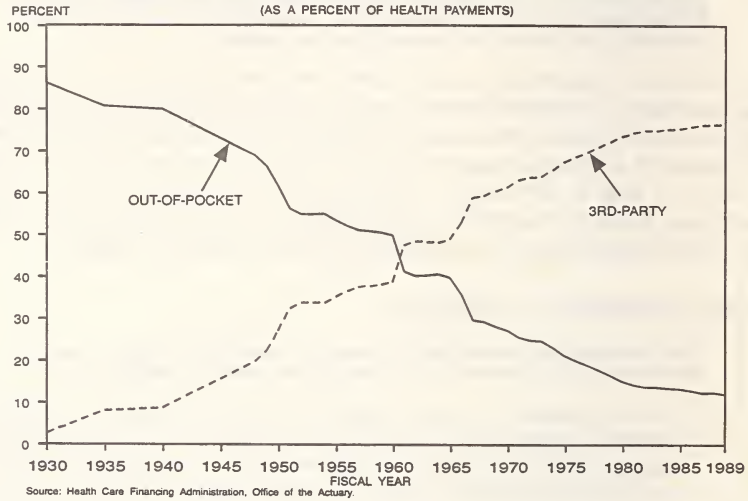
The causes of the health cost explosion are multiple—and not easy to disentangle in a way that points reliably to a stable solution.

(a) It is clear that health costs have exploded as third-party payments have displaced individual out-of-pocket payments for health. (See chart 17.) Common sense suggests a causal connection. And some empirical evidence suggests that greater out-of-pocket cost-sharing by individuals could help reduce excess utilization. But, while desirable, there has been evident resistance to this. The trend toward third-party payment seems to be a long-term secular trend—influenced by a combination of public-spirited concerns for equity, tax incentives, and private desires (both rational and "irrational") for insurance coverage. Further, evidence suggests that while cost-sharing can usefully influence individuals' decisions whether or not to visit a doctor, once in the care of a doctor, individuals often defer to doctors. That is, health service suppliers—not consumers—tend to become the determinants of the quality and quantity of care.

(b) Whatever the cost and regulatory strains on the system, *physicians' incomes do not seem to have suffered.* They *averaged* $155,800 for 1989—widening their lead over physicians in all other countries.

(c) *It is possible to distinguish several contributing elements of national health spending growth:* general inflation, population growth, relative aging of the population, growth of volume and intensity of care, and medical inflation in excess of the CPI. For the past three decades, total health spending has increased an average of 11.29 percent per year. After adjusting for general inflation and population, real per capita health spending has increased by 4.77 percent per year. Almost all of that has been accounted for by medical inflation in excess of the CPI (1.54 percent) and by growth in volume and intensity per capita (2.59 percent). (*See chart 18.*) Over the long term, medical visits and inpatient admissions per capita have been relatively stable; and average hospital length of stay has actually declined. *The increase in service intensity per capita seems to have been the most significant contributor* to real per capita health expenditure growth. (*See chart 19.*)

CHART 17. 3RD-PARTY VS. OUT-OF-POCKET HEALTH PAYMENTS:
THE INDIVIDUAL HAS BEEN DISPLACED IN THE HEALTH PAYMENT SYSTEM



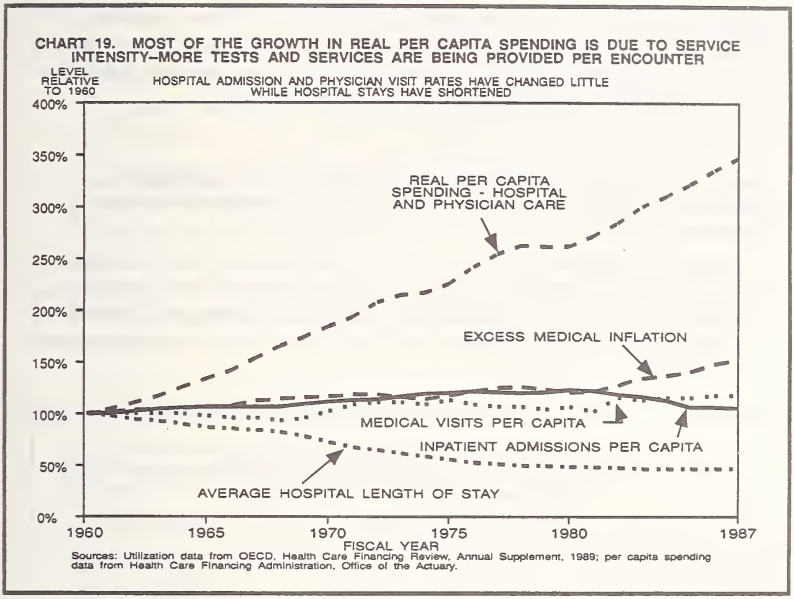
Source: Health Care Financing Administration, Office of the Actuary.

Chart 18. Elements of Growth in National Health Spending

(Average Annual Percent)

	1960–1970	1970–1980	1980–1989	1960–1989
Nominal National Health Spending	10.61	12.85	10.35	11.29
General Inflation.....	2.76	7.81	4.65	5.07
Population	1.27	1.06	0.99	1.11
Real Per Capita Health Spending ..	6.29	3.58	4.41	4.77
Real Per Capita Health Spending.....	6.29	3.58	4.41	4.77
Volume and Intensity Per Capita....	4.54	2.09	1.02	2.59
Medical Inflation in Excess of CPI..	1.52	0.39	2.87	1.54
Relative Aging of the Population	0.17	1.00	0.48	0.55
Real Per Capita Health Spending.....	6.29	3.58	4.41	4.77
Real Per Capita GNP	2.84	1.34	1.64	1.95
Health Spending in Excess of GNP	3.36	2.21	2.73	2.77

Source: Health Care Financing Administration, Office of the Actuary.



(d) But while it is possible to make these interesting statistical observations, *it is difficult to go beyond them* and determine definitively how much of the volume and intensity growth is due to genuinely valuable *technological advance,* how much due to excessive *"defensive medicine,"* how much due to *managerial ineffectiveness,* and how much due to *gaming of a price-regulated system* in order to keep income rising.

(e) Experience with many of the health system reforms tried to date provides *a substantial record of unintended (and often undesired) secondary effects*—as "simple" solutions have been applied to a complex system.

There seems to be an *inherent dilemma* in the area of health care. Because medical diagnosis and prescription have been largely in the hands of the professional provider, not the consumer, consumer-based market discipline has been weak. The problem is compounded by the apparent fact that consumers themselves tend to be risk-averse when it comes to health. That is, they are inclined to "overconsume" (relative to what economic optimization would dictate) in order to keep risk as close to zero as possible. Providers, of course, have incentives to over-provide or over-price—unless there are meaningful competitive restraints, or aggregate caps on available income. Meaningful, market-oriented competitive pressures have been difficult to establish for reasons of politics, consumer attitudes, and market structure and dynamics. Costs, and associated frustrations, have therefore mounted. And with them, have come increased tendencies

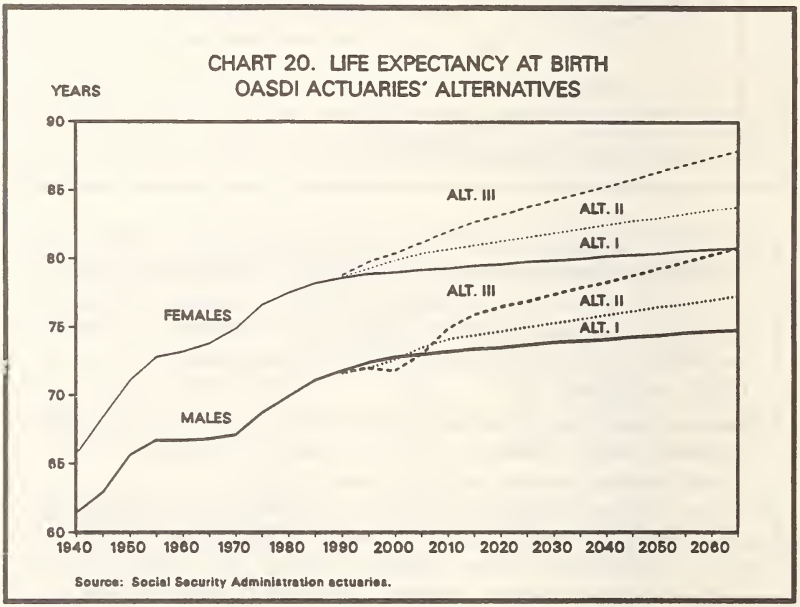
43-866 O - 91 - 6

toward anti-market-oriented regulatory reactions. But partial regulatory "solutions" only lead to gaming. And comprehensive regulatory "solutions" tend, over time, to lead to inefficient resource allocation and/or rationing. A way out of this dilemma that is both politically viable and substantively sound is not immediately evident.

SIMPLE OBSERVATION NUMBER (8):

Strategies to continue to improve life expectancy are desirable—but they do not necessarily reduce (and may substantially increase) system-wide costs.

(a) *Average life expectancy at birth has been rising steadily, and is projected to continue to do so.* (See chart 20.) From the standpoint of those who value life (i.e., almost all of us), this is unquestionably a favorable development. But from the standpoint that is concerned about rising health expenditures, it may be a mixed blessing—as discussed below.



(b) Net economic benefits to society can be positive if people who are enabled to live longer are also able to be productive. *But there are several types of cases where this test is not met.* For example:

(i) where infant mortality is reduced, but other factors influencing subsequent life chances—e.g., remediation of disability; provision of opportunity to escape a poverty environment—are not addressed;

(ii) where relatively sudden natural death (as, e.g., from heart attack) is avoided, only to substitute slower natural death (as, e.g., from Alzheimer's);

(iii) where natural death is prolonged by technological advances sufficient to prevent death, but not sufficient to restore healthy functioning; or

(iv) where the period of healthy functioning is extended (beyond age 65, say), but opportunities (or incentives) for productive activity are not.

(c) This is not to suggest that life should not be extended in such cases. As a matter of political, socio-psychological, and ethical reality, it is likely that society will wish to invest in the extension of life without much regard to economics. This is a testament to the strength of the human spirit. But given this strength, the point is: *complementary policies need to be pursued to increase the likely productivity of lives that are extended—or else the net cost to society will continue to mount.*

SIMPLE OBSERVATION NUMBER (9):

If not only average life expectancy, but also maximum life span are likely to increase, budgetary considerations will become an important additional justification for raising the retirement age.

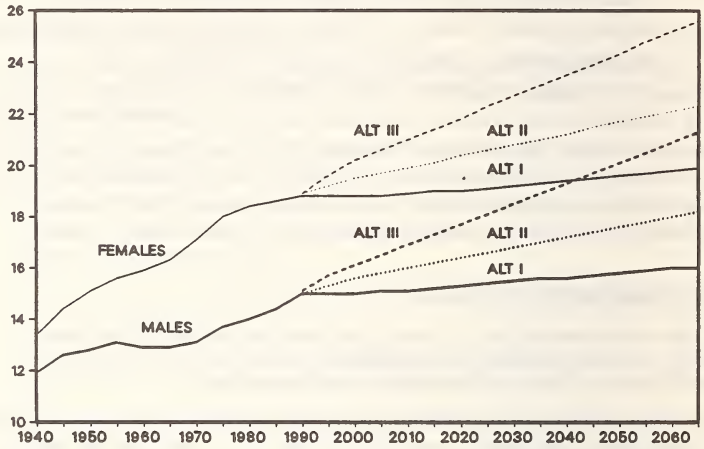
(a) Not only is life expectancy at birth increasing; but *life expectancy for those who reach age 65 is also steadily increasing.* (See chart 21.) Further, the *percentages of the population surviving to ages 65 and 85 have been steadily increasing.* (See chart 22.) And large percentages of those who are living longer are remaining healthy longer.

(b) *But the retirement age has not been increasing.* As a result, the percent of the population that is healthy-but-retired is increasing. For those who benefit from longer, healthier retired lives, this is clearly desirable. But longer retired life for more people can become a growing economic burden for those who are working. Although not directly a matter of health policy, *this increasing economic burden is, in effect, a consequence of some of the successes of health policy* (and the associated failure to keep retirement in line with such successes).

(c) While average life expectancy is rising, the natural upper limit on human life span may not be (or may not be rising much). How much this upper limit might rise is a matter of scientific dispute. But it is not inconceivable that the current investment in basic research, genetic research, and biotechnology may produce *breakthroughs that could significantly increase the upper "limit" of human life span.* If such breakthroughs were achieved—or were likely—the need to adjust retirement policies would be still greater.

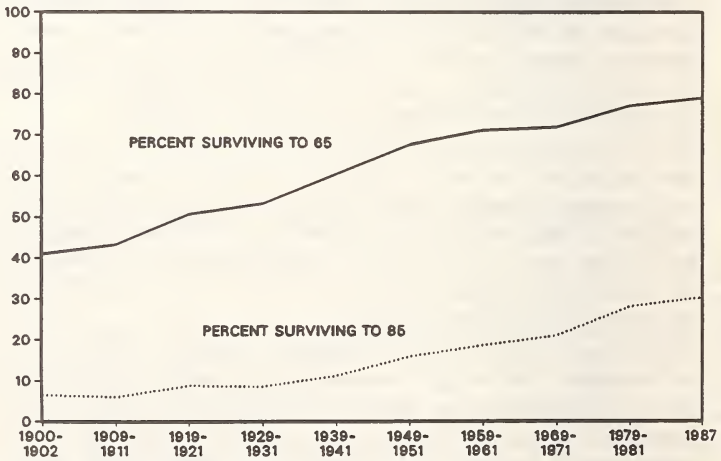
NOTE: Current Social Security and Medicare projections do *not* assume such breakthroughs. With current demographic assumptions, relatively modest changes in the retirement age translate into large budgetary savings. By way of illustration: If the normal retirement age were gradually raised to 69 by the year 2022 (starting in the year 2000), savings would be greater than $25 billion (in 1992 dollars) per year.

CHART 21. LIFE EXPECTANCY AT AGE 65
OASDI ACTUARIES' ALTERNATIVES



Source: Social Security Administration actuaries.

CHART 22. SURVIVAL RATES TO 65 AND 85,
TOTAL POPULATION



Source: U.S. Vital Statistics, 1987.

SIMPLE OBSERVATION NUMBER (10):

Although proposals to increase access and reduce health costs abound, and some partial solutions make some sense, no comprehensive solution yet advanced is without its share of serious problems.

Because this subject is inherently difficult and complex, and because none of the currently competing "solutions" is satisfactory, the Administration continues its internal work on comprehensive reform. This work is going on under the extraordinarily able direction of the Secretary of Health and Human Services, Louis Sullivan.

For the time being, the Administration is advancing publicly only those health initiatives in which it has a high degree of confidence (whether or not they relate directly to the cost and access issues):

- increasing investment in *health research and development;*
- targeting resources on *infant mortality reduction and maternal health improvement;*
- increasing the focus on *prevention* and *personal responsibility;*
- starting the process of *reducing subsidies for the non-poor;*
- creating incentives for the more widespread adoption of *malpractice reform* by the States;
- continuing to limit the rate of growth of selected *physicians' fees;* and
- evaluating the *natural experimentation* in both cost control and access reform that is going on among the States.

Among these Administration initiatives are proposals for five-year budgetary savings that exceed $25.6 billion. I regret that, at this point, the Congressional Budget Committees have not accepted these—or any other—cost control proposals.

While the Administration does not yet have sufficient confidence in the merits of any one of the more comprehensive health system reform proposals, I am aware of the Finance Committee's interest in these, and have included for your convenience:

- *Attachment (1)*—a summary description of most of the major health reform proposals now being debated in the public domain;
- *Attachment (2)*—a preliminary descriptive analysis of the comparative merits of these plans as alternative approaches to cost containment; and
- *Attachment (3)*—a preliminary descriptive of the comparative merits of these plans as alternative approaches to increased access.

These descriptive analyses are strictly preliminary and should not be construed as arguing for particular conclusions with respect to comprehensive reform.

Please let me conclude by noting: I would be pleased to discuss the points I have touched upon in this Statement—or any other matter you might wish me to try to address—in response to your questions.

I commend the Committee for its serious and timely attention to this important subject. And again: I thank you for giving me the opportunity to provide this introductory perspective.

Attachments: (1), (2), (3)

Summary of Comprehensive Health Reform Proposals Now Being Debated

Cost Containment	Heritage	AEI (7/90 Pauly Draft)	Enthoven (3/91 Draft)	H.R. 1565 (Johnson)
Cost-Sharing	Higher cost sharing encouraged thru tax policy.	Higher cost sharing encouraged thru tax policy.	Higher cost sharing encouraged thru tax policy.	"Safe harbor" for 30% overall cost sharing.
Managed Care	Managed care encouraged thru tax policy.	Managed care encouraged thru tax policy.	Managed care encouraged thru tax policy.	"Safe harbor" for "managed care" plans.
Limit Tax Subsidy for Employer Paid Health Benefits	Replaces exclusion with refundable tax credit for individuals & families	Replaces exclusion with refundable tax credit for individuals & families	Caps exclusion for all workers at lowest priced plan provided thru small employer purchasing group. For small businesses, income exclusion is available only if coverage is obtained thru small employer group.	25% tax penalty for employer if employer share of premium is greater than $160/$300 a month unless 30% cost sharing or managed care.
Price Regulation	No	No	No new regulation	No new regulation
Supply Regulation	No	No	No	No
Other	No	No	Preempt state mandates for insurance purchased thru small employer group.	Preempt state mandates for small business; insurers must offer a basic coverage plan. Preempts state "anti-managed care" laws.
Access				
Scope of Coverage	Universal	Universal	Near universal	Expands, not universal
Benefits	Catastrophic coverage w/ high deductible	Basic w/ income related out-of-pocket cap	Basic	Basic
Medicaid Expansion / Buy-In	Retains Medicaid with expansion and buy-in.	Replaces Medicaid with private coverage thru tax credit.	Thru small employer purchasing group w/ sliding scale premiums.	No
Tax Credits and Subsidies	Tax credit varies as percent of actual premium cost.	Tax credit varies by income and health risk.	Special tax credit for small employer premiums in excess of 8% of payroll.	Increases premium deduction for self employed to 100%.
Individual Mandate	Yes	Yes	No	No
Employer Mandate	No	No	Yes, play or pay mandate	Employer must offer coverage, but not required to pay.
Universal Public Insurance	No	No	No	No
Who Pays				
Government / Financing	Repeal of income exclusion for health benefits & other funding.	Repeal of income exclusion for health benefits & other funding.	Cap on income exclusion for health benefits & other funding.	Financing not specified
Employers	Voluntary	Voluntary	80% of tax cap amount	
Individuals	Difference between premium and credit.	Difference between premium and credit.	Excess above employer contribution.	
Small Employer Market	Not specifically addressed.	Replaces private insurance cross subsidies with health-risk adjusted tax credit.	Small employer purchasing groups &"community" rating.	State must implement "market reforms" or Federal preemption
Quality	Not specifically addressed.	Not specifically addressed.	Health plans must gather outcomes data.	Requires outcomes data for hospitals.

$---/$-- refers to individual/family coverage.

Summary of Comprehensive Health Reform Proposals Now Being Debated

Cost Containment	UNY*Care	S. 768 (Kennedy)	Pepper Comm'n	H.R. 8 (Oaker)	Canada
Cost-Sharing	Unspecified, but out-of-pocket costs would be capped on sliding scale.	Maximum permitted: 20% coinsurance, $250/$500 deductible; $3000 cap.	Maximum permitted: 20% coinsurance, $250/$500 deductible; $3000 cap.	Maximum permitted: 20% coinsurance, $200/$500 deduct; $1000/$2500 cap.	None allowed
Managed Care	Employer financing may encourage managed care	Employer financing may encourage managed care.	Employer financing may encourage managed care.	No incentives are provided.	Little utilization review. Few HMOs; no PPOs.
Limit Tax Subsidy for Employer Paid Health Benefits	No	No	No	No	n/a
Price Regulation	All-payer rate setting	No new regulation	No new regulation	All-payer rate setting	Gov't monopsony
Supply Regulation	Certificate of need regulation.	No	No	Capital budgets	Capital budgets Limits on manpower
Other	Lower billing costs thru single payer.	Practice guidelines	Malpractice reform. Practice guidelines. All-payer utilization data.	Commission to assess technology and set coverage standards.	Strong regional management by provincial governments.
Access					
Scope of Coverage	Near universal	Near universal	Near universal	Universal	Universal
Benefits	B	B, M	B, P, M	B,P,M	B, P, M
Medicaid Expansion / Buy-In	Yes, but few specifics are provided.	Modified public program w/ expansion to 100% of poverty & buy-in to 185%.	Federalized program with expansion and buy-in.	Replaces Medicaid with universal program: public/private hybrid.	n/a
Tax Credits and Subsidies	For low-income families.	For small businesses, subsidy to covers 75% of premiums in excess of 5% of gross revenue.	Credit covers 40% of premiums for small businesses w/ average wages < $18,000.a year.	No	n/a
Individual Mandate	No	No	No	No	No
Employer Mandate	Play or pay mandate	Play or pay mandate	Play or pay mandate with phase-in for small business	No	n/a
Universal Public Insurance	$25,000 stop loss would be provided by state	No	No	Hybrid - public finance with private insurance	yes
Who Pays					
Government / Financing	Redirects gov't charity care/bad debt payments. Other not specified	Financing not specified	Financing not specified	Financing not specified	Fed. income tax and provincial payroll tax
Employers	Responsible for most	80% of premiums	80% of premiums		Provincial payroll tax
Individuals	At employer option: workers responsible for up to $250/ $500 a year. Sliding scale for others.	At employer option: workers responsible for up to 20% of premiums. Sliding scale between 100 - 185% of poverty	At employer option: workers responsible for up to 20% of premiums.		
Small Employer Market	"Market reform"	Community rating	"Market reform"	Community rating	n/a
Quality		Practice guidelines	Practice guidelines Outcomes research	Commission to establish standards w/ enforcement	

B = Basic health care, P = preventive services; M = mental health care (inpatient and outpatient psychiatric). $---/$-- refers to individual/family coverage.

Summary of Comprehensive Health Reform Proposals Now Being Debated

	1. H.R. 1565 (Johnson)	2. S. 700 (Durenberger)	3. Pepper Comm'n	4. NAIC*	5. Enthoven
Implementation	Federal preemption unless state meets Fed. std. Fed. regulation enforced thru tax code. NAIC to have opportunity to develop implementing regulations.	Federal preemption unless state applies for waiver to operate its own program.	Not specified Presumably would involve significant Federal role.	State legislation	After phase-in, for small business workers, health benefit tax subsidy would be available only for coverage purchased thru an accredited Health Insurance Purchasing Corp.
Guaranteed Issue (must cover all groups & not exclude any member)	Yes	Yes	Yes	Yes	Yes, for coverage purchased thru a HIPC.
Guaranteed Renewability	Yes	Yes	Yes	Yes	Yes, for coverage purchased thru a HIPC.
Exclusions for Preexisting Conditions	Limited	Limited	None allowed	Limited	None allowed.for HIPC coverage.
Rating Limits					
Within Demographic Category	Premiums may not vary by more than ±25% from midpoint	Premiums may not vary by more than ±20% from midpoint	Premiums may not vary within demographic category (e.g., "adjusted community rating").	Premiums may not vary by more than ± 25% plus up to 15% for industry	Premiums may not vary within category (e.g., "adjusted community rating") for HIPC coverage.
Between "blocks of business"	Premiums may not differ by more than 20% from hi to lo.	Same as (1)	Not specifically addressed.	Same as (1)	Not specifically addressed.
Limit on Annual Premium Increases	To be established by NAIC	% increase for new business plus adjustment for change in benefits	Selective rate increases based on group experience would be prohibited.	% increase for new business plus benefit changes plus 15% a year	n/a
Enforcement	Actuarial certification. Monitoring by state insurance commissioner.	Same as (1).	Not addressed.	Same as (1).	HIPCs would monitor insurers compliance with contract terms.
Reinsurance	States can design their own system. Federal back-up provided.	Not addressed.	Not addressed.	Not finalized. Several options, including voluntary & mandatory options.	n/a
Core Benefit Plan	Covers hospital, physician & preventive services. Scope can be be modified.	Covers hospital, physician, diagnostic, ambulance, prenatal & DME services.	Covers hospital, physician, diagnostic, preventive & mental health.	Scope of basic & std. coverage to be specified in regulations.	Basic coverage
Other	Employers must offer basic coverage but needn't pay. Prohibits mandated benefits & restrictions on selective contracting.		After phase-in, employers must provide minimum benefits or pay tax. Subsidies provided to assist small business with costs.	Carriers must offer basic & std. coverage. Prohibits mandated benefits & restrictions on selective contracting.	A HIPC is a non-profit corporation controlled by its small business members. Provides for group purchasing of health insurance. States would certify one (or more) per area.

* Two industry groups, the Blue Cross Blue Shield Association and the Health Insurance Association of America, have developed their own market reform proposals. These are similar to the approach being developed by the NAIC, but there are significant differences in the type of reinsurance mechanisms being advocated.

Preliminary Descriptive Analysis of Cost Containment Options

	1. Incentives for Cost Sharing	2. Incentives for Managed Care	3. Limit Tax Subsidy for Employer-Paid Benefits	4. Government Monopsony	5. All-Payer Rate Setting	6. Supply Controls
Where proposed?	Johnson (directly). Enthoven, AEI, Heritage (indirectly).	Johnson (directly). Enthoven, AEI, Heritage (indirectly).	Enthoven, AEI (Pauly Draft), Heritage*	Canada	Oakar, UNY*Care	Canada, UNY*Care
Potential Advantages	Cost sharing has been shown to reduce health spending with little impact on health outcomes. Little overhead cost.	Provides framework and incentives for cost-effective care delivery. Selective contracting may strengthen price competition. May reduce unneeded care.	Strengthens competition encouraging increased cost sharing & managed care. Could improve equity if revenues used to fund expanded access.	Used with apparent success by other nations. Substantial administrative savings may be possible.	Similar to (4) but leaves private insurance somewhat intact. Retains some incentive for managed care.	Has had modest effect on health spending growth. Market forces alone may be insufficient to correct imbalance in physician supply.
Potential Disadvantages	Some consumer resistance likely. Little impact on service intensity. Little effect likely on price competition.	Some consumer resistance likely. Difficulty of defining managed care. Savings from provider price competition may be limited.	Impact on cost is indirect. Potential for inequitable impact (depending on detailed design).	Would disrupt U.S. health system. Major increase in taxes and role of government. Weak incentives for efficiency. Price competition eliminated.	Could limit access. Major increase in regulation & role of gov't. Could weaken incentives for managed care.	Could limit access and create shortages that US public may not accept. Potential adverse impact on quality & innovation.
Impact on Costs	Depends on degree of cost-sharing.	Substantial savings possible, but lag time needed to develop effective managed care plans & build enrollment.	Similar to (1) and (2), but indirect.	May not work in U.S. Admin. cost savings. Could have rapid cost control effect, after initial start-up.	Comparable to (4), except less potential for administrative savings.	More likely to limit spending for "high tech" care.
Impact on Unnecessary Care	Could reduce "needed" as well as "unneeded" care; little evidence.	Has potential for reducing unneeded care.	Similar to (1) and (2), but indirect.	Little direct effect.	Little direct effect.	Could reduce some unneeded care
Impact on Health Care System	Little impact.	Major change, but consistent with trends.	Could trigger shift to managed care & competition.	Expands regulation. Increased opport'y for political intervention. Could slow movement toward managed care.	Similar effects as (4), but less extensive.	Little disruption over short run. Major potential for disruption over long run.
Impact on Quality and Innovation	Concern about quality impact, but little evidence to support. Little innovation impact.	Concern about quality, but little evidence. Concern about limiting choice.	Similar to (1) and (2).	Little short run effect. Potential for underfunding could have adverse effect.	Same as (4).	Potential adverse effect.
Impact on Role of Government	Little impact.	Defining managed care may increase gov't role.	Little impact.	Major increase in gov't role.	Similar effect as (4), but less extensive.	Similar to (4).
Implementation and Other Issues	Could have adverse effect on equity if low-income protections not included.	Monitoring required to determine compliance with managed care standard.	Tax cap could have inequitable impact due to variation in premium costs.	Minimum of 2 yrs lead time needed.	Same as (4).	Would likely require hospital-level capital budgeting to have impact.

* Enthoven limits the income exclusion for employer paid health benefits with a dollar cap. AEI and Heritage totally replace the income exclusion with a new health insurance tax credit. Distinctive implications of the Heritage and AEI approach are discussed more fully in the analysis of access options.

4/15/91

Attachment 3

Preliminary Descriptive Analysis of Access Options

	1. Medicaid Expansion With Buy-In	2. Individual Mandate & Tax Credit Based on Income & Health Risk	3. Individual Mandate & Tax Credit Based on % of Premium Cost	4. Employer Play or Pay Mandate	5. Universal Public Insurance
Where Proposed?	Kennedy, Pepper Comm'n, UNY*Care	AEI (7/90 Pauly Draft)	Heritage	Kennedy, Pepper Comm'n, UNY*Care Enthoven	Canada
Potential Advantages	Builds on current program. Matching of Fed.& State funds.	Universal coverage. Blends individual rights and responsibilities. Targets subsidies based on need.	Similar to (2) but tax credits are not targeted based on need.	Retains private insurance system. Relatively low cost to gov't.	Perceived equity. Potential for cost control.
Potential Disadvantages	Expands gov't reach with associated problems. May be perceived as "second class care" for beneficiaries. Burdens States with more costs.	Potentially high gov't cost due to transfers to employers and low-risk workers. Disrupts risk pooling in private insurance that keeps premiums low for high risk individuals.	Only catastrophic coverage required -- may be inadequate for many (but tax credits available for broader coverage). Disrupts risk pooling as (2).	Passes cost to private sector. Will reduce employment and economic growth. Could depress wages for low-income workers.	Major increase in gov't role and cost. Political system in U.S. may fail to control costs. May limit diversity & innovation.
Impact on Access	Covers half the uninsured.	Universal basic coverage.	Universal catastrophic cost coverage.	Covers about half of the uninsured.	Provides universal coverage.
Approx. Annual Cost for Gov't	>$30 billion in Federal/state costs.	Difficult to estimate.	Difficult to estimate.	Could lowers Federal/state Medicaid & indigent care cost	$200-300 billion.
Transfers	$5-10 billion to providers. $7-10 billion to households. Compared with (2) & (3) less potential for transfers to employers.	$10-15 billion to providers. Substantial transfers to young, healthier workers, and to employers (if employers reduce premium contributions for low-wage workers to take advantage of the tax credit).	Similar to (2).	$5-10 billion to providers. $10-15 billion to households.	$10-15 billion to providers. $25-30 billion to households. $150 billion to employers.
Impact on Insurance & Delivery System	Substantially expands gov't reach.	Could reduce gov't role by replacing Medicare/Medicaid w/ credit & private insurance	Could reduce gov't role by replacing Medicare with voucher.	Builds on current private insurance system. Substantially expands gov't reach.	Eliminates most private insurance.
Implications for Cost Containment	No significant effect likely.	Could result in less employer involvement which could weaken pressure for cost containment.	Similar to (2), except sets tax credit based on percent of actual premium costs.	Concern that political system will be overly generous with employers' money. Retains employer incentive for cost containment.	Depends on politics.

Prepared Statement of Senator Charles E. Grassley

[April 9, 1991]

Thank you, Mr. Chairman.

Thank you for calling this hearing today on a very important topic which is going to occupy much of our attention on this committee and in the Senate for the next year and perhaps for the duration of this Congress and beyond.

As we all know, and as testimony before the committee today will indicate, there is growing dissatisfaction with our health care system. At the same time, however, there is really no consensus as to what to do about it. The public doesn't appear to want to pay more for health care—and why should they—given that our national health care bill is now running over $600 billion a year? The public also appears to be relatively satisfied, those of them with access to the system, with the health care services they receive.

At the same time, we have a desperately serious situation of more than 31 million people who have no health insurance coverage. And, at one time or another, as many as 25 percent of the American people may be without health insurance. In my own State of Iowa, one responsible analysis concluded that about 13 percent of our State's population lack health insurance coverage. we really can't tolerate this situation.

Even those who have health insurance are concerned as, in many cases, their premiums keep mounting. As we all know, this is a particularly serious problems for small business and the employees of small businesses.

As I noted above, however, what to do about these problems is another question. Virtually every serious step we might take to deal with the central problem of health care cost increases, beyond what we have already done, is very controversial.

I believe that it is very important to remember, also, that very large percentages of people who do have access to health care are quite satisfied with the services they receive. To me, this means that we have to proceed with great care.

So, hearings like this, in which we give a good airing to some of the issues involved, are very much necessary to help get the American people involved in the discussion and clarify for them and for ourselves the choices we realistically have before us.

Prepared Statement of Edward L. Hennessy, Jr.

I want to thank the Committee for this opportunity to share with you Allied-Signal's experience and views on the challenge of providing quality, affordable health care.

Our company is a $12 billion advanced manufacturer serving the aerospace, automotive and engineered materials markets. In this country, we have operations in 35 states employing about 76,000 workers. My purpose in citing these facts is to point out that we have a large number of employees, with dependents, who work in several industrial sectors and across the nation. Health care coverage is a prominent part of the compensation and benefits package for all of these people.

In 1988, Allied-Signal implemented a company-wide program that has been described as the boldest and most forward looking corporate effort yet devised to provide quality health care at an affordable cost.

I'd like to tell you that our decision to totally rethink the way we provide health care benefits was the outgrowth of our keen understanding of the problem and our farsighted vision. The facts, however, are far less dramatic.

Like other major U.S. corporations, Allied-Signal has learned through hard, firsthand experience the threat posed by runaway medical care costs.

For years, we had struggled to break through the chronic pattern of rising costs through measures like higher deductibles and coinsurance payments, hospital preadmission certification, mandatory second surgical opinions and the use of more than 100 HMOs nationwide. These measures controlled the rate of growth for a while, but all they really did was treat the symptoms without attacking the underlying illness.

In 1987, however, our health costs went on the critical care list. That year our health care bill surged 39 percent, and our projections showed a continuing annual growth rate of about 20 percent for the next several years.

We realized that we needed a totally new approach. We recognized that in order for cost containment measures to succeed they had to be aimed not just at health care consumers, but at health care providers as well. So, just about three years ago, Allied-Signal became the first major employer in the U.S. to create a managed

health care system—uniform in design and managed by a single insurer—on a national scale.

At the heart of the program is a health care provider network organized by our insurer. The network now covers more than 50,000 employees and their dependents. Employees choose a primary care physician who is a member of the network. This doctor, who serves as the coordinator of all the employee's health service needs, is prepaid by the insurer—CIGNA—every month.

The primary care physician, usually an internist or family doctor, provides basic care and is responsible for making the necessary referrals to specialists, or hospitals. We believe that these medical professionals are far better qualified to make judgments regarding the coordination of health care services and the need for them than an insurance representative or other administrator might be.

Behind the primary care physician, the network has an array of specialists, therapists, labs, and imaging units. In addition, the program includes regional medical centers—called Centers of Excellence—that are recognized for their expertise with special treatment needs or challenging surgical procedures such as organ transplants.

Employees using network providers pay no annual deductible, and most services are covered in full. There is, however a $10 co-payment for office visits and a $5 co-payment for prescription drugs. More importantly, the program encourages preventive care and offers annual physical exams and special services like vision and hearing exams and well-child care. As we all recognize, preventive care is far more cost efficient over the long-term than the therapeutic treatment of a disorder.

Another distinctive feature of our plan is that it preserves the employees' freedom of choice. They can, at any time, decide to use a provider who is not in the network. But it costs them. Outside the network the plan requires an annual deductible of one percent of yearly base pay—3 percent for a family—and a 20 percent co-payment. These costs are, of course, steeper than the in-network expense but they are competitive with many "fee for service" indemnity plans that are available throughout the country. And, the Allied-Signal employee always retains the option of using in-network services at any time.

Employee acceptance of the new program varied from place to place. Generally, acceptance has depended upon two factors: how strongly the individual feels about the reduced freedom of choice, and the degree of resistance to the managed care concept from the local medical community.

Initially, our program also suffered from some administrative and start-up difficulties as we learned the nuances of operating a point-of-service plan. Those difficulties were corrected, however, as claims handling and other procedures were improved.

Approximately 80 percent of our employees covered by the managed care plan use the network 95–100 percent of the time.

What have the results been? Well, our latest figures show our corporate costs have been 27 percent lower for employees using the new plan than they would have been using a typical fee-for-service indemnity plan. Savings per employee are projected to be $1,244 this year.

So, I think it is fair to say that Allied-Signal, as well as other companies embracing managed-care programs, such as Marriott, Sears and Proctor & Gamble, are tackling the health-care affordability issue.

But what about the *quality* of the care provided? In Allied-Signal's case, we believe the quality of the health care our employees are receiving has remained high. Certainly, the high percentage of network utilization would suggest that the level of care provided meets our employee's quality expectations.

At the same time, we have sought to reduce the sense of "entitlement" that surrounds health care in this country. Our in-network providers are capable of offering first-class health care to our employees. However if desired, the "opt-out" provision that I mentioned a moment ago allows an individual to seek alternative medical care. But they must come to terms with the need to pay for that decision. Health care costs will never be brought under control in this country if there is not some elemental link between the service desired and the need to pay for it.

To look at the situation from a different perspective, there is no evidence to suggest that our country has improved the quality of health care by throwing money at the problem. On the contrary, the familiar statistics on infant mortality rates and other measures suggest that the vast sums we are now spending simply aren't getting the job done.

Part of the problem is that we know very little about the quality of our health care, despite the many initiatives that are underway in the area of outcomes research. In fact, we probably know more about the quality of our automobiles, com-

puters and other manufactured goods than we do about this basic human service. In the absence of any clear quality standards, many individuals make the assumption that high cost means high quality. And why shouldn't they? For the majority of Americans someone else is paying the bill—for 60 percent of the population that means their employer.

Of course, there are other reasons for our runaway medical costs. For one thing, as Americans live longer they are consuming more medical services. There's also the high cost of new technologies like magnetic resonance imaging. And, there is that ever present threat of medical malpractice which causes health care providers to practice a defensive and very expensive brand of medicine and to pay high insurance rates.

But I believe that the core problem is the "blank check" mentality that nearly all of us bring to our medical care. Over the years we have developed the expectations in our society that, while the individual is responsible for providing such necessities of life as food, clothing and shelter, medical care is an entitlement—the responsibility of others.

We shouldn't be surprised that competition in the market for food, clothing and shelter yields ample supplies at reasonable cost and quality. In the medical care field, however, where there is no competition, the opposite is true: doctors and hospitals tell us what we need and how much it costs. And, we pay—with no questions asked. Or—to be more precise—someone else pays, and, until recently, they haven't been asking questions either.

Allied-Signal's managed care program—like similar programs—is designed to forge a partnership that includes the health care provider, the employee, the company and our insurance carrier to manage the cost and the quality of our health care services. In short, we are striving to do away with the "blank check" mentality.

The issue of cost-efficient health care, however, is larger than any one company or group of companies can hope to resolve alone. There is a clear need for the Federal Government to help wrestle this national problem back to manageable proportions.

There are a number of reasons why a Federal initiative is essential. The most urgent concern is for the millions of Americans currently without health care insurance—that's an intolerable situation. At the same time, the relentless growth of health costs is continuing to erode our competitiveness in the international marketplace. Health care costs represent a substantial but largely unrecognized surcharge on virtually all U.S. manufactured goods. In the case of car makers such as Chrysler, there are estimates that health costs add as much as $500 to the price of a new car—twice as much as for French and West German automakers and three times as much as for the Japanese.

I can tell you that despite all the efforts on the part of U.S. manufacturers today to drive down our operating costs and dramatically improve the quality of our goods, we will succeed in the world market if our health care expenses remain so seriously out of line with those of our principal competitors.

So what should the Federal Government do?

For starters, I believe that the Federal Government should use its considerable weight and influence as an employer to adopt managed care nationally for Federal workers. Managed care is not a panacea, but we do believe that it is part of the larger solution to the problem. Put another way, government employees should not help perpetuate the fee-for-service system which is among the least cost effective.

Next, the Federal and state governments should support private sector efforts to control health care costs through a renewed emphasis on employing cost containment strategies like managed care.

In particular, small businesses must be supported in their efforts to curtail escalating health care costs. Without the bargaining advantages that large corporations enjoy, small businesses are at a big disadvantage in negotiating rates with insurance carriers. So, if the Fortune 500 companies are seeing their health care insurance costs climb by 10 or 20 percent a year, small companies are swamped with increases of 30, 40 and 50 percent. Increases of this magnitude will severely inhibit the well-documented ability of small businesses to generate substantial job growth in the 90's.

One possible solution to the problem is for smaller companies to form their own associations or networks in order to wield greater influence and to bargain for better deals with health care providers. But some states currently prohibit businesses from joining forces to buy health coverage. Those laws are counter productive. Federal legislation permitting and encouraging such networks would have a moderating effect on health costs for many smaller businesses and their employees.

Finally, the Congress must come to terms with the need for positive reform in Medicare and Medicaid programs. The current expedient of simply reducing the re-

imbursement levels only shifts the payment burden to insured private employers—especially those who, for one reason or another, have been unable to bargain with health care providers to control their costs. The hard truth is that Medicare and Medicaid costs are increasing sharply and it is time for the American public and our legislators to stop ducking the issue through a cost-shifting sleight-of-hand. We will never fix the problem if we are afraid to confront it.

Here again, we would encourage the use of managed-care programs to help deal with soaring Medicaid costs. Recently, a managed-care project for any many as 35,000 Medicaid patients in Brooklyn received the approval of New York state authorities. Other programs like this must be initiated elsewhere in the country in order to determine how managed-care networks can best meet the Medicaid patients and lower health care costs at the same time.

However, I am skeptical of proposals to solve our problems by superimposing on existing programs a massive and untried national health program.

Without laying claim to special technical expertise in this area, let me cite a few which do seem promising. Make health care premiums completely deductible for self-employed individuals. Consider targeting tax credits to small firms which can document their inability to purchase affordable health care coverage. Identify and remove the regulatory barriers I mentioned earlier which prevent small business from banding together to achieve greater market power in negotiating with providers.

Don't invent new systems to cover the poor and near-poor who make up a disproportionate number of the uninsured; instead fix the Federal program which was designed to address their needs—Medicaid. If effective cost controls can be established, phase in expanded coverage to all who fall below the poverty level. For the near-poor—with incomes close to the poverty line—allow a "buy-in" for a low-cost basic package of benefits.

In conclusion, I think all of us—public policymaker and private business alike—must recognize that we'll probably never see a decrease in health care costs—not with our aging population and the baby boomers headed for retirement in about 20 years. But, even if we could bring the annual rate of increase down in to the single digits, it would be a significant victory in which we could all share.

Thank you.

Prepared Statement of Senator John D. Rockefeller IV

Thank you Chairman Bentsen. As usual, you have gathered an impressive round of witnesses.

As evidenced by today's panel of CEOs, health care and the cost of it is one of the biggest challenges facing American businesses today.

As important as slowing down the rate of increase of health care costs, there is an uneasiness felt by most American families that they are just a health crisis away from not having adequate health insurance coverage. While health insurance coverage was initially devised to give peace of mind, many families are discovering that is no longer the case.

The Pepper Commission heard countless stories of the financial and emotional consequences of getting sick or having a family member get sick in the United States of America. In West Virginia, we heard testimony from a man who lost his family's health insurance coverage the day his wife had surgery for uterine cancer. It's to the point that unless you are lucky enough to work for a large company that is able to spread its health care costs, and therefore its risks, over a large number of workers, you may be out of luck—and out of health insurance—when you or a family member develop, or are born with, a severe health condition. People, with diabetes or epilepsy—to name just 2 examples—are literally afraid to change jobs. Pre-existing condition clauses that now exist in most health insurance policies means that they put themselves at-risk for large medical bills for a significant period of time when they switch jobs, if they are lucky enough to even get coverage.

In addition these concerns, I think we are all deeply disturbed by the large number of Americans—most of whom are workers and one-third of whom are children—whom do not have a health insurance card. Not having a health insurance cards means, for all practical purposes that you are locked out of what most of us consider a incredibly sophisticated and technologically superior health care system.

While I do not expect to hear any easy or magic solutions to the twin problems of access and cost, I do think today's witnesses will be able to provide useful and insightful testimony on where and how they think we should begin to tackle these issues. And, I must admit, that I am personally hopeful that Dick Darman will take

note of the depth and the scope of the problem as presented by those testifying today.

Again, thank you Chairman Bentsen for your leadership on this issue. I know that that health care is an issue you personally care deeply about, and I look forward to working with you, this year, on ways to stabilize health care costs and bring about better health protection for our citizens.

PREPARED STATEMENT OF RHODA H. KARPATKIN

Mr. Chairman and Members of the Committee, I am Rhoda Karpatkin, the Executive Director of Consumers Union,[1] the publisher of *Consumer Reports.* I greatly appreciate this opportunity to share our views on the crisis in American health care. In recent years, few topics have so dominated our concerns as the failure of the health care system to accommodate all citizens.

Most recently, *Consumer Reports* published a 2-part series, *The Crisis in Health Insurance,* in the August 1990 and September 1990 issues. The reader response to these two articles was impressive. The letters were extremely personal and moving accounts of tragedy and despair due to the lack of access to affordable health care.

Our health care system is the costliest in the world. The U.S. spends 171 per cent more per capita than Great Britain, 124 per cent more than Japan, 88 per cent more than West Germany and 38 per cent more than Canada. We pay more, much more—but get less. We lag behind numerous countries in important health indicators. As this Committee is well aware, 37 million Americans are not covered by health insurance at all and at least 60 million may be underinsured for much of any given year.

Individuals without health insurance have many faces. They may be poor, since only 38% of the poor receive Medicaid. But increasingly, lack of insurance coverage is a middle class phenomenon. Individuals finding themselves uninsured or uninsurable include:

(a) men and women employed by small businesses
(b) the self employed
(c) part-time workers
(d) young people just starting their careers
(e) the disabled
(f) the divorced
(g) those taking early retirement, but still too young for Medicare
(h) workers whose employers go out of business
(i) those with pre-existing conditions
(j) students

With the present patch-work private insurance system, everybody—rich and poor, employed and unemployed, male and female, young and old—is at risk of being without health insurance. Even those of us who feel our employer-provided policies protect us well could be just one illness or one accident away from losing both our health insurance and our savings.

Our August 1990 article told the story of David Curnow, formerly a partner in a San Diego law firm. He was injured in an accident, when (while riding his bicycle) he was struck by an uninsured motorist. While his insurance carrier paid most of his bills (which totaled nearly $250,000), he has considerable out-of-pocket costs for the home-health aide services he needs every day. But before long, his health insurance benefits will run out. Eventually he will qualify for Medicare because of his disability, but he will be unable to get coverage for expenses not covered by Medicare. If he is able to return to work, it is not very likely that he will find a firm that has an insurance company willing to accept the health risk he poses.

While there is growing understanding that a large per cent of the poor have inadequate health insurance and limited access to health care, recognition that the

---

[1] Consumers Union is a nonprofit membership organization, chartered in 1936 under the laws of the State of New York to provide information, education, and counsel about consumer goods and services and the management of family income. Consumers Union's income is derived solely from the sale of *Consumers Reports,* its other publications and films. Expenses of occasional public service efforts may be met, in part, by nonrestrictive, noncommercial contributions, grants, and fees. In addition to reports on Consumers Union's own product testing, *Consumer Reports,* with approximately 4.9 million paid circulation, regularly carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

health access problem is a major problem for the middle class is more recent. The case above of a partner in a law firm shows how an accident can suddenly create a health insurance problem for someone who not long before was a gainfully employed, healthy person.

The middle class can be affected in many other ways as well. Since many employers have dropped or cut back on their health insurance benefits, many relatively well-paid employees, especially individuals working in small firms, may lack access to an affordable health insurance policy.

Consumer Reports told the story of a small employer in California whose health insurance premiums doubled in one year, with premiums for one employee of over $10,000 per year. Over half of the non-elderly population without health insurance are working adults. And the spiralling health care costs are leading to high premiums that force the middle income consumer—both employees of firms and the self employed to drop coverage in too may cases. In 1987, 25 per cent of the uninsured worked for very large employers who offered health insurance.

Moreover, the number of employers paying premiums is declining. In 1984, Hewit Associates, a benefits consulting firm, found that 37 per cent of large employers paid full premiums for their workers. By 1988, only 24 per cent provided these benefits.

Consumer Reports noted that 48 per cent of the low wage members of the Service Employees International Union (whose members are hospital workers, janitors, and government employees) were offered insurance but turned it down because they could not afford the premiums. Health conditions of some employees, like Kay Nichols (who, at age 38 has glaucoma) lead employers to be either locked-into existing health insurance policies (unable to shop around for a lower-priced policy) or to face difficult-to-accept exclusions from new policies.

Working Americans can lose their health insurance when their employer goes out of business. When individuals not covered under a group policy seek out coverage for their families, they discover a bleak marketplace. Even less than adequate coverage may cost thousands a year, with premiums ever rising. Individuals shopping for coverage soon discover that insurers want to cover fewer and fewer people. Insurers compete ardently for the healthiest applicants. While no carrier wants to cover individuals who have had a history of cancer, heart disease, or life threatening illnesses, increasingly insurers are turning down people with far less serious health conditions. Virtually no commercial carrier, and only a handful of Blue Cross and Blue Shield companies, will sell policies to anyone who has had heart disease, cancer, diabetes, strokes, adrenal disorders, epilepsy, or ulcerative colitis. Treatment for alcohol abuse, depression or even visits to a marriage counselor can mean rejection. If you have less serious conditions, you may get coverage, but on unfavorable terms. Some insurers will offer coverage, but only if the preexisting condition is excluded. Companies in our survey told us that between ¼ and ½ of their policies carry exclusion riders, higher than standard premiums or both.

Moreover, if you are rejected, that fact will be recorded at the Medical Industry Clearinghouse, which is accessible to insurance carriers. The clear message to consumers is that only those in excellent health need apply. People who have medical problems, however minor, are second class citizens in the world of health insurance.

Other middle income consumers are affected by the health insurance quagmire because their health insurance concerns lock them in to their present jobs. Pre-existing health conditions and the fear of losing critical health benefits keep them from being able to change jobs, or careers.

We are deeply concerned that people are forced to make career decisions purely based on health insurance issues. They may be unable to accept new and more promising positions because of insurers' "existing conditions" practices. It is entirely possible that fears about health insurance may be stifling the mobility and motivation of workers in American companies.

The lack of health insurance affects people's health and often has deadly results. *Consumer Reports* told the sad story of John Andrusyshyn who died of a malignant melanoma, after treatment was delayed because he delayed going to the doctors since he could not afford to pay another bill. He was not eligible for insurance from his employer until he had been on the job for a year. There are many tragic examples like this one. In response to these articles, one reader with an annual income of $11,000 wrote that a hospital would not perform his wife's needed cancer operation because of his inability to pay $7,000 up front.

It is especially troubling that many Americans become educated about the inadequacies of our health care system just when they already have major problems on their hands: a severe accident an acute illness, the development of a chronic health

condition, the loss of a job. It seems especially unfair to burden people with what amounts to an unsolvable problem just when other crises hit.

Women without adequate coverage are particularly at risk for bad health outcomes. Uninsured women are much less likely than insured women to have screening tests for breast cancer, cervical cancer or for glaucoma. If they are pregnant, they often do without prenatal care. Five million women between the ages of 15 and 44 are covered by private health insurance that does not include maternity coverage. Lack of prenatal care translates into babies who are too small when they are born and babies who die soon after birth. The U.S. trails 22 other nations in infant mortality behind Germany, Spain, and Singapore.

The health care problem has many dimensions, including the critical need for controlling costs. When the uninsured are unable to afford health care, everyone pays. In 1988, unpaid hospital bills totalled more than $8 billion—up 10 percent from the previous year. To recoup the costs of unpaid care, doctors and hospitals raise the price for everyone else. This cost shifting in turn drives up the price of insurance, resulting in more people not being able to afford coverage. Cost shifting accounts for about one-third of the increase in insurance premiums which are rising as much as 50 percent a year. The cost of medical care—which is increasing 2 to 3 times faster than the rate of inflation—accounts for the rest.

During the past 50 years, health care expenses (as a percent of gross national product) have grown rapidly.[2] In 1940, national health expenditures were 4.0 per cent of GNP. The per cent rose to 8.3 per cent in 1975, and to 11.1 in 1987.[3] The corresponding figure (in 1986) for Britain is 6.2 per cent, for Canada is 8.5 per cent, and for Germany is 8.1 per cent.[4] If present trends continue, health care will consume 15 per cent of GNP in the year 2000.[5]

Insurance companies are beginning to pay close attention to what their dollars are buying. Insurers are now more involved in monitoring the quality of treatment and determining whether the treatment was appropriate to the condition. Some programs require policyholders to seek second opinions before undergoing surgery, to use hospital outpatient facilities for specified procedures, to use certain doctors and hospitals and to obtain approval from insurance companies before starting a proposed course of treatment. While these measures may have some minimal effect on costs, these controls on doctors have created a new field of health care cost management—one of the fastest growing fields in the health care area. Health care cost management firms are expected to generate $7 billion in revenue in the next few years—revenue that will, of course come from insurance premiums. These expenditures contribute not one iota towards improving health care for people who need it.

These firms are expert in teaching doctors how to bill for their services and maximize reimbursement. Firms in the business of "doctor reimbursement and coding" sell thick books and sponsor seminars that tell physicians how to beat the system. Brochures tout, "You'll improve your reimbursement or get your money back." The primers sold by these firms tell physicians how to choose certain billing codes over others that would net them less income. To fight back, insurers are rebundling the bills that come into their claims departments. Indeed a rival industry has sprung up to scrutinize bills for evidence of billing practices promoted by the coding and reimbursement firms.

For instance, ERISCO, a subsidiary of Dun and Bradstreet, offers computer software that will rebundle a $2,500 bill for performing an appendectomy ($1,500) with a laparotomy ($1,000), the latter being simply an incision in the abdomen. Once the computer program has rebundled the bill, the doctor will receive only $1,500 for the appendectomy and nothing extra for making the incision.

No one knows yet whether insurers or doctors will win this war. What is certain is that the battles are costly and the money being spent on this expertise is doing little to improve the health of Americans.

Consumer Reports concludes that the best approach that could both provide universal access to high quality health care while controlling costs is a model that features a single payer, rather than thousands of private carriers competing for the

---

[2] Robert B. Henderson, M.D., Health Care in the United States Metropolitan Insurance Companies, 1982, p. 15.

[3] Source Book of Health Insurance Data, Health Insurance Association of America, 1989, p. 49, quoting, U.S. Department of Health and Human Services, Health Care Financing Administration Health Care Financing Review, Winter 1988.

[4] Ibid., p. 48.

[5] For the Health of a Nation: A Shared Responsibility , Report of the National Leadership Commission on Health Care, Health Administration Press Perspectives, Ann Arbor, Michigan, 1989, p. 3.

healthiest applicants. Meaningful reform must provide for universal access to health care; cost containment; mechanisms to ensure quality of care; elimination of administrative waste; and long-term care for the elderly and disabled.

We are encouraged that the Senate Finance Committee is undertaking a serious examination of the American health care system and look forward to working with this Committee to move the concept of universal access to health care towards a reality for our Nation.

Prepared Statement of Lane Kirkland

Mr. Chairman, members of the Committee, thank you for this opportunity to testify on this most critical issue to working people and their families.

At long last, this nation has reached an important milestone in the century-long debate over health care reform.

The AFL-CIO has long been on record in calling for Federal legislation to assure all Americans access to essential health care services at a price they can afford. Now, for the first time, we find ourselves in broad alliance with many of our traditional opponents on this issue.

This phenomenon is not due to a surrendering of objectives or goals on the part of any particular group, but rather a recognition by all sides of the urgency of the crisis at hand and the immediate need for new initiatives toward cooperation and compromise.

Gone are the old hardened attitudes and political posturing. Organized labor, organized medicine and many in the business community are offering proposals to achieve the same three objectives: lower costs, expanded access and improved quality of care. This represents true progress toward resolution of these problems.

The time is right, Mr. Chairman, for Congress to take advantage of this growing consensus and to take the lead in fashioning a program of national health care reform that will achieve these important goals and stem this crisis before it impoverishes the bulk of the American middle-class.

Clearly, we are heading down that road. The health care tragedy is no longer confining itself to the fringes of our society. It's now striking at millions of solid, working, taxpaying families—people who are the backbone of our country, who do their level best to pay their bills and meet their obligations.

Our dubious distinction as a nation is that we continue to tolerate a health care system that is more costly than any other and falls far short of the universal coverage provided throughout the industrialized world.

The figures are well known. At present, nearly a third of the country has either no health insurance or insurance that is inadequate to meet their needs. Last Fall, in a series of eight AFL-CIO regional hearings, we met some of the victims of this crisis—Americans for whom health care has become a luxury unavailable to them and their families.

They are the workers with children whose employers do not offer health care coverage or for whom the price of such coverage is unaffordable.

They are the sick—victims of severe or chronic illness—who are no longer acceptable risks to insurers.

They are the elderly who are covered by Medicare but can no longer afford the high out-of-pocket payments and the uncovered services that are so crucial to maintaining their independence and quality of life.

They are the working poor who do not meet arbitrary state-by-state criteria for Medicaid coverage.

They are the insured who cannot afford the high deductibles and copayments necessary to use their coverage.

They are the desperate, seeking care in hospital emergency rooms for serious illnesses that would have been prevented if they had early access to treatment.

The huge numbers of Americans who fall into one or more of these categories point to only one conclusion—our health care system is not working anymore. It has failed a vast portion of working Americans who have done the best they can to maintain coverage at a reasonable cost.

The American health care system operates on the principle of Social Darwinism and we have paid dearly for it. It punishes employers who provide health insurance to their workers by forcing them to, in effect, subsidize the health care of those who are employed by firms which seek a competitive advantage by refusing to provide such coverage. That forces the cost of coverage to rise sharply, and millions of Americans who are fortunate enough to be covered by health insurance have, as a result, suffered the financial burden of increased cost-shifting and reductions in ben-

efits. Moreover, the system rewards purchasers with large groups or relatively young workers with short-term discounts, and it penalizes small employers and those with older, more experienced workers by forcing them to pay more for coverage.

I submit that a nation which wants to be competitive in the 21st Century cannot continue to give these kinds of incentives to employers who place such a low value on maintaining a healthy and productive workforce.

Yet this is exactly what we do. And it obviously is not helping us rein in costs. Our rate of increase in total health care expenditures continues to soar at a 20 percent annual rate. As a percentage of gross national product spent on health care, the U.S. spends at least 40 percent more than any other industrialized country and as much as 70 percent more than our major competitors in the world market.

At the same time, our current system does not arm consumers or providers of care with enough information about quality. Practice standards are established on a facility-by-facility basis with strong incentives for providers to practice costly defensive medicine. In addition, the paperwork required by public and private insurers has forced physicians to spend almost as much time supervising the processing of forms as providing patient care.

In short, the current crisis demands immediate action and the labor movement is united in its pursuit of fundamental restructuring of the system.

Although we have drafted specific proposals for your consideration, let me be clear that the AFL-CIO is not committed to any single plan. Instead, our objective is to maintain an open mind and work with all who share our goals toward the development of legislation that can muster the support necessary for enactment. We are in a negotiating posture and we intend to approach it in a practical way, working with this Committee and with the leadership in the Senate and the House.

We have four essential goals:

CONTAIN THE GROWTH IN HEALTH CARE COSTS

To achieve this objective, we urge Congress to:

- Establish a uniform national cost containment program by extending the cost containment methodology used by Medicare to all payors, with reimbursement levels set through a negotiation process involving consumers, purchasers, government and providers under the auspices of a national commission.
- Put a system-wide cap on the rate of increase in total health care spending.
- Establish a capital budgeting system to encourage the efficient distribution of capital, which will minimize the unnecessary duplication of equipment and reduce the large numbers of empty beds still in the system.

ACCESS TO MEDICAL CARE FOR ALL AMERICANS

To achieve this objective, we urge Congress to:

- Establish a core benefit package to which all Americans are entitled.
- Require all employers, including the Federal Government, to contribute fairly to the cost of care for workers and their families.
- Put an end to the patchwork quilt of Federal and state health care programs and establish one Federal program for those not in the workforce by using Medicare to cover all Americans not eligible for employment-based coverage, including the unemployed and those currently receiving protection through state Medicaid programs.

REDUCE WASTE, RED TAPE AND PAPERWORK

Recently, there has been a growing interest in reforming insurance practices in the small group market. While we support such long-overdue reforms, the AFL-CIO believes that far more needs to be done and that reforms should be developed by Congress—not the states—to assure uniformity across the country. Specifically, we believe regulation is warranted to:

- Put a stop to current insurance practices that keep individuals and employers out of the health system or force them to pay contributions that are disproportionately high. This would involve broad pooling of risk, minimum data requirements and standardized claims forms.
- Set minimum standards for entities offering so-called "managed care." This would eliminate much of the confusion in the market-place and level the playing field for organized systems of care that meet Federal requirements.

• Improve the quality of care through by developing practice guidelines for physicians and a national strategy to reform the current system of handling malpractice disputes.

SOLVE THE RETIREE CRISIS

The issue of retiree health care has become one of the most difficult at the bargaining table. The new accounting regulations put forth by the Financial Accounting Standards Board (FASB) that go into effect in 1993 would require companies—for the first time—to list on their Balance Sheets estimates of liabilities for providing health care benefits to current and future retirees. The new regulations have caused a number of employers to cut back coverage for future retirees or eliminate protection altogether. Such actions have already seriously increased the number of retirees without coverage and the problem is growing.

We believe that the most effective way of responding to this crisis is to make the age of eligibility for Medicare more consistent with the average retirement age. Specifically, we propose reducing Medicare to age 60. This would spread the cost of retiree health care over the entire population and no longer disproportionately penalize employers who have attempted to protect their retirees against the high cost of getting sick.

CONCLUSION

Our proposals are based on the experiences of millions of American working men and women for whom the current health care system has become a nightmare.

They are the ones who feel the sting of repeated cost containment exercises that have done little to limit the soaring cost of health care.

They are the ones who are losing access to a health care system that purports to be the best in the world.

And they are the ones who face the prospect of injury and illness without any idea on how they will pay for the decent and humane treatment they deserve as citizens of the world's greatest industrial power.

Mr. Chairman, there is real suffering going on out there. Nothing short of full scale reform will solve our problems. We have reached the stage where quick fixes no longer are possible and where "voluntary efforts" no longer offer promise.

For its part, the AFL-CIO is prepared to consider each and every proposal that purports to address the three issues of cost, access and quality. We are prepared to work with you and your staff and to work in coalitions with consumers, employers and providers to develop an approach to national health care reform that takes the best of the systems around the world and is "made in the U.S.A."

Prepared Statement of Gary Kushner

My name is Gary Kushner, and I am the President of Kushner & Company, a small business and an employee benefits consulting firm from Kalamazoo, Michigan. Kushner & Company helps small businesses establish and maintain employee benefits plans. I am testifying today on behalf of National Small Business United, where I serve as chair of its Health Care Policy Subcommittee.

National Small Business United (NSBU) is the oldest trade association exclusively representing small businesses in this country—for over 50 years now. NSBU is a volunteer-driven association of small businesses from across the country, founded from a merger of the National Small Business Association and Small Business United. NSBU serves over 60,000 individual companies with members in each of the 50 states, as well as local, state, and regional associations. We are proud to say that our surveys show that approximately 80% of NSBU members offer health coverage for their employees.

For the last two years, we at NSBU have made health care reform our very top priority and concern. There are two distinct needs of the small business community regarding reform of the health care system: (1) systemic cost control to bring a halt to the seeming endless upward spiral of health care costs and reduce the share of GNP going for health care; and (2) reform of the market within which small businesses operate in order to purchase insurance for their employees.

I. HEALTH CARE COSTS

Employers of all kinds and sizes are finding it increasingly difficult to finance the cost of the health care of their employees. It is appropriate, then, that the health care debate in this country does not center around whether we are spending enough

on health care; surely our spending outstrips any real necessity. The U.S. spends more per capita on health care than any other country in the world—more than double what Japan spends and 40% more than Canada, which is the second most expensive country. Twenty five years ago, health care consumed 5.9% of the GNP; in 1991, that number will top 13%, of total of more than $750 billion. This year, 36% of the growth in our GNP will be eaten up purely in increased health care costs.

Individual Responsibility

Why is it possible for these costs to continue to escalate in this way? Because there are currently very few checks within the system to counter these hikes. Most Americans have very low deductibles and co-payments and have very few personal incentives to check cost increases. And, insurance companies—except to some degree where there is a managed care program—have no way to control expenditures and physician and patient choices, so their high costs are simply passed on in the form of higher premiums. Corporations, large and small, have been unable to agree on how to control rising health care costs.

In a sense, then, we have high health care costs largely because so many people never actually face any meaningful part of their health care bill. The combination of Federal tax incentives and state mandates serve to encourage insurance-based financing of a broad range of benefits at fairly low levels of deductibles. This arrangement keeps patients insulated and prevents them from behaving like normal consumers, who would otherwise seek a lower price for the same level of care. In order to be serious about cost containment, we must seek to inject a greater degree of consumer responsibility and sensitivity into the health care market.

There are also other reasons that health care costs continue to rise. For example, malpractice costs continue to escalate and must be dealt with. Hospital capital expenditures continue to soar; these costs must be reduced because many of the purchases are unnecessary. Medical advances continue to make more procedures possible, thereby increasing aggregate health care. Finally, the high technology of these medical advances is very expensive in its own terms. Clearly, there are good solutions to some of these cost problems, but not for all of them.

COST SHIFTING

But there are additional reasons for cost increases on the private sector, other than the aggregate cost of health care. There are three major groups who finance the costs of health care in this country: (1) the government, (2) self-insured companies—generally big corporations, and (3) businesses which insure through traditional insurance companies—generally small businesses. Together with individuals, these groups finance virtually all of the nation's health care spending. It is important to realize that, to the extent that one of these groups pays less, the others pay more.

The recently implemented DRG system for Medicare expenses has had good success in reducing the government's health care expenses. However, it has done nothing to lower the overall costs of health care and has actually driven up costs for the privately insured. When providers cannot get adequate compensation from the government, they simply raise the prices charged to everyone else. Large, self-insured plans frequently have a great deal of clout in a given area and can negotiate with providers in order to reduce the impact of this "cost shift" on themselves. However, small employers have no ability to reduce this cost-shift and must bear its full brunt. This same cost-shifting scenario also holds true for provider's expenses in delivering uncompensated care, primarily to the uninsured. For these reasons, no part of the business community is hit harder by the high costs of the uninsured than small business.

II. SMALL BUSINESS PROBLEMS

However, the health care cost problems of small employers cannot simply be dealt with at the macro level. There are unique equity problems faced by small businesses in financing the care of their employees, which go to the heart of how health care should be paid for—whatever its costs happen to be. These issues revolve around how small employers find and maintain adequate insurance coverage for their employees.

The insurance market for small employers revolves around individual rating. All employees—and each of their dependents—of a small firm are screened for past and present health conditions, and their individual premiums are set accordingly. If individuals in these groups have conditions, those conditions are routinely excluded from coverage. At the very least, dramatically higher rates are charged for these

employees (and to some extent, all employees). Moreover, small employers with sick employees are frequently turned down for coverage altogether. When an employee gets sick while a given policy is already in effect, renewal time often finds the employer faced with premium increases which make the plan unsustainable. When this employer shops for a new plan, other insurance companies either will not provide coverage or they will exclude from coverage the condition of the sick employee. These employers are often faced with the Hobson's choice of discontinuing coverage for a given individual in order to find coverage for everyone else.

These insurance market problems are aggravated by the fact that small businesses employ a disproportionate number of older workers, part-time workers, and women—all of whom tend to have higher-than-average premiums. Small business insurance premiums are also increased by the very fact that they must be individually rated. It is very expensive to individually rate employees, and those costs are passed on to the business.

To illustrate the gravity of the problem in the small group insurance market, a survey from the late 1980s by the HIAA estimated that employers with fewer than 25 employees pay about 30% higher premiums than large employers. Further, the General Accounting Office (GAO) reports that the premiums for those small employers have continued to rise at a rate 50% greater than the rate of increase for all other employers. Therefore, the problem is not simply that all insurance—even that of large corporations—is too expensive (though it is); the problem is that small, marginal companies actually get a substantial and discriminatory price *hike.*

The insurance industry argues that the major reasons for this disparity are the high acquisition and administrative costs for small firms, combined with their relatively low renewal rates. Insurers' marketing costs are higher per business (because there are so many small businesses to which to market, and so few who actually buy from any particular company) and must be continuous because their book small firm business is constantly revolving. One of the major reasons for higher-than-average premiums for small businesses is that they are always switching insurance companies (called "churning"). Why is this churning so prevalent?

A major reason that small businesses switch insurance companies so frequently is that their premiums frequently get substantial hikes after the first year of coverage. One of the major reasons these hikes occur is because pre-existing condition exclusions often expire after the first 12–18 months of coverage. The resulting premium increases often push small companies into switching plans, which serves both to further escalate costs and to perpetuate the under-insurance of their employe—because they suffer a new round of pre-existing condition exclusions. Also, the competitive pressures on insurance companies may encourage them to price a product at levels that are not sustainable past the first year. Premiums may also increase if new employee conditions have become present.

These underwriting practices for small employers cause a given employer to essentially bear the full cost of a particular employee's health claims, rather than spreading the costs across a larger pool. While this situation may be comparatively good news for small businesses that have a healthy work force, it can be devastating for those who have employees with expensive illnesses. We must move back toward an insurance system that groups individuals in order to spread the risk of an individually large loss across a larger group. As it stands now for many small employers, insurance is merely financing their real costs and billing them back to the business, rather than spreading risk across larger populations.

III. NSBU RECOMMENDATIONS

NSBU is in the midst of formulating a revision to our health care policy stand. The outlines of a plan has been finalized at the committee level, but awaits Board approval. I intend to speak from this plan with the understanding that there could be some changes before it becomes association policy.

Basic Package

There should be a basic Federal package which insurers in the small business market would offer to small businesses. First, the plan would preempt all costly state mandates and replace them with Federal guidelines. These state mandates require all insurance company-issued policies to cover a list of very specific conditions; individuals are not allowed to choose less broad or costly insurance. Beyond driving up insurance prices in the obvious ways, these mandates are also a problem since they vary from state to state, making it impossible for insurance companies to offer uniform packages. Moreover, state mandates only apply to insurance offered through insurance companies; big companies which self-insure are not required to comply. Therefore, state mandates should be replaced with a more well-defined and

equitable Federal basic package. The basic package we would recommend includes the following:

(1) Hospitalization
(2) Inpatient and outpatient physician services
(3) Surgery
(4) Those preventive care remedies which are proven cost effective (see below)

Deductibles for such care would be set at $1,000 for individuals or $2,000 for families, with a 75/25 co-pay for costs up to $6,000; insurance would pay 100% for additional expenditures, capping individuals' maximum health care expenditures at $2,500 per year. Additionally, the basic package would cover the first-dollar costs of pre-natal care, neo-natal care (for up to one year), and mammography—as these have been proven cost effective.

The plan identifies maximum deductibles, not minimum ones. Obviously, if it appeared that this level of deductibles might not be sustained, it maybe necessary to discuss other ways of encouraging individuals to accept greater individual responsibility for health care costs.

We have suggested a basic package which has relatively high deductible levels essentially because the current distribution of health care expenditures is a result of the large number people having first dollar health coverage. Billing an insurance company rather than an individual allows providers to charge more and to recommend care which might have otherwise been deemed unnecessary. Furthermore, insulation from costs causes consumers to seek out and accept unnecessary care. And, by and large, the people who have the most extensive first dollar insurance coverage are those people who could most afford to pay for every-day routine care themselves. What we essentially have is too much insurance for the people who need it the least. The solution to this problem of over-insurance and over-utilization of the system seems to be to try to encourage greater individual responsibility for individual health care expenses, but to also ensure access to insurance to guard mainly against unexpected and catastrophic health care costs.

We would recommend that this basic package could only be amended by a supermajority in Congress (perhaps ⅗) and the President's signature. The temptation is simply too great to continuously expand this package, but to do so would be to incrementally return to the situation we have today.

Insurance Reform

The insurance reforms recommended by the subcommittee would tend to be a leveling force for health insurance premiums across the board; the size of the group would play a much smaller role in determining premiums than is currently the case. The reforms suggested make a serious move toward community rating, yet they stop short of pure community rating; there would still be room to rate based upon age, sex, and region of the country, for instance.

Assuming other factors remain constant, an injection of community rating may well (though not necessarily) raise premiums somewhat for employers who have a very healthy workforce. Yet, overall, aggregate premiums paid by the small business community would decline, and the individual problems small employers face in continuing to insure someone who has become ill would be erased. It would also become much easier and less complex for a small business to compare premiums and shop for insurance companies.

The insurance reform being offered by Senator David Durenberger (S. 700) appears to correspond to many of our recommendations. Though the Durenberger plan goes further in terms of detail than we have so far gone and takes a somewhat different path in how it preempts state mandates, S. 700 seems to be a good outline from which to proceed on this issue. It moves toward more community rating for small business by restricting pre-existing condition exclusions, guaranteeing renewability, limiting year-over-year increases. The Durenberger approach enforces its insurance reforms for the small employer market by imposing an excise tax on insurers which do not comply, and I believe this would be sufficient to bring about the reforms he discusses.

A potential danger in the area of insurance reform is that it could act to drive insurers out of the small business market. We must be very careful as we proceed in this area to ensure that we produce a product which insurance companies will want to sell and that small companies will be able to buy. At the same time, or primary objective should be to level the playing field for the purchase of health insurance, such that any business could expect to have access to the system

Access

In terms of access, we would require individuals, as a course of citizenship, to purchase health insurance (the basic package) or to otherwise be protected against large health care expenses—in much the same way that drivers are required to purchase auto insurance and individuals are required to buy into the Social Security system. There should be penalties for those who do not purchase insurance, though a subsidized pool should be established for the uninsurable. Whether an individual wishes to purchase insurance through an employer (when it is offered), through a spouse's or parent's employer, from a private health insurance company, or through a potential pool (if the individual is eligible) would be left up to the individual.

We believe that such a system will still allow and encourage the facilitation of health insurance through employers. An individual mandate will create additional competitive pressures for employers to provide insurance for their employees, and this fact should lift the provision of insurance by employers to levels significantly above where they stand today. Since these competitive pressures could present financial hardships for some small employers trying to meet them, it is absolutely critical that this individual mandate only occur when accompanied by meaningful cost containment.

Obviously, in order to facilitate the purchase of this health insurance, consideration needs to be given to those individuals who could not otherwise afford it. Since it is obvious that the poor could afford neither a $1,000 deductible nor premium expenses, a variable (to income) tax credit could help those without sufficient resources afford insurance premiums, as well as up-front deductibles. Of course, this credit should only be available to the poor who are using it to purchase health care and insurance.

Such an individual mandate would solve most of our cost-shifting problems and should dramatically reduce the rolls of the uninsured (if properly paired with a financing mechanism for the poor). Moreover, such a mandate allows the move toward community rating mentioned above. Community rating is not really feasible and efficient if healthy individuals are allowed to opt out of the plan while the sick can painlessly opt in; it could not really be done—for instance—in today's health care marketplace.

Malpractice Reform

In order to constrain medical costs and reduce unnecessary care, we should institute several reforms. First, practice protocols should be established in order to give treatment guidelines to physicians, which would provide an affirmative defense against tort claims if followed. Next, a cap should be placed on the total amount of punitive awards, and losers in malpractice cases should pay court costs and attorney's fees. These reforms are aimed at reducing the enormous health care costs which can be directly traced to our high rate of malpractice suits. These suits drive up health care costs two ways. First, they drive up overall costs by impelling physicians to provide care which may not be necessary. Second, the sky-rocketing malpractice insurance premiums are simply passed on to patients, insurance companies, and—ultimately—employers.

Focused Cost Containment

On a national, state, and local basis, health expenditure review boards should be established to control health care costs. Rather than leaving it up to the negotiations physicians and insurers, this board would play a role in determining, capping, or at least arbitrating the pricing levels for "reasonable and customary" care. In addition, the review boards would gather and analyze data regarding performance, quality of care, and outcomes—on a national, state, and local level. This data would be used to measure the performance of health care dollars vis-a-vis the overall health of the community.

The boards would bring together consumers, payers, and providers to establish budgets for operation of facilities and capital and equipment investments. Some changes in the federal antitrust laws may also be needed to allow cooperative ventures to reduce specialization and duplication within local health care delivery markets.

Further, providers should be subject to mandatory disclosure provisions. This provision would require providers to disclose full costs of care, where possible, ahead of time. This disclosure would allow patients and third-party payers to more discriminately control costs.

In addition to such a system, pricing health care provided to those in small groups according to Medicare rates could also go a long way toward bringing meaningful cost control to the small business health care market.

One other suggestion I have is to strengthen the ability of small businesses to utilize medical reimbursement flexible spending accounts, authorized under Section 125 of the IRS Code.This is a useful tool for many small employers that has come under attack by the IRS. I would be willing to go into greater detail during Q & A if you desire.

We very much want to thank you for providing the opportunity for us to present our point of view. If we can be of further assistance in the future, or if you need any additional information, we stand ready to move this issue forward in any way we can.

PREPARED STATEMENT OF KENNETH A. MACKE

Good Morning. I am pleased to have this opportunity to register with you my deep concern about the predicament our country's medical delivery system is in. I also want to offer several carefully considered ideas for reform.

I am Chairman of the Board and Chief Executive Officer of Dayton Hudson Corporation. We are one of America's largest general merchandise retailers . . . with annual sales of $15 billion.

You are probably more familiar with the names of our stores . . .

—Target,
—Mervyn's,
—Dayton's . . . Hudson's . . . and Marshall Field's.

Altogether, we have more than 700 discount and department stores in 33 states. We are the nation's 16th largest employer. That is the reason I am here today. We have approximately 60,000 employees (working 24 hours or more per week) and their dependents covered by medical insurance.

I have been with Dayton Hudson Corporation for 30 years—all of my career—and for six years, I have been CEO. During that six-year period, our corporation's medical expenses have grown from $60 million in 1985 to $115 million in 1990. Part of this increase is due to our growth as a company. But most critical is the fact that our per-covered-employee cost has increased from $1,108 to $1,649 in those same years.

For example, in 1985, a routine appendectomy cost about $2,500. Today, it can easily cost $6,000. In 1985, normal childbirth cost $2,000. Today the average cost is $4,500. Another way of looking at the magnitude is to realize that we have to sell over 39,000 Ninja Turtle action figures to pay for one appendectomy.

In the early 1980's, we began an aggressive program aimed at cost containment. To accomplish this,

—We are self-insured for all but HMO coverage.
—We use claims management on high cost cases.
—We do utilization reviews.
—We make use of managed care and bargained rates for transplants at regional transplant centers.
—We use our size to influence HMO practices.
—We have tightened what we offer to our employees by charging significant employee premiums . . . including deductibles and co-payments . . . and
—We have increased the administrative requirements of the plan through second opinions . . . pre-admission procedures . . . and a host of other disciplines.

In spite of all these things, in 1990 alone, our total medical expenses per-covered-employee increased 15 percent. This picture is even darker for smaller companies that fully insure. For that group, premiums increased a minimum of 23 percent in 1990. And we have learned that, even in our medically-competitive state, where HMO's are a heavy influence, market forces cannot solve the problems.

As a nation, we spend 12.4 per cent of our GNP for health care. And yet, medical care effectiveness in the United States is no better than other nations that are spending as little as one-third of what we spend.

The experts estimate that if we don't do something about this NOW, annual medical expenses in our country will go from the current $735 billion per year to over $2 trillion and over 20 percent of GNP by the year 2000. I am equally alarmed that an estimated 37 million Americans do not have access to medical insurance.

Because of costs universal coverage can be afforded only if we have basic reform. The delivery system has major flaws which must be corrected. The best experts have concluded that about a third of what is done in health care does not produce anything of value because of excessive and inappropriate treatment. Present admin-

istrative burdens represent waste. Malpractice costs (defensive medicine, costly litigation, malpractice insurance) are draining billions of dollars.

As hospitals see doctors, rather than patients, as their primary customers, hospitals feel compelled to provide the most sophisticated equipment and technology. This results in excess investment for equipment and excess cost to payors. Research and development is decentralized and disorganized to the point that it is often inconclusive and unusable. Access to medical insurance is based on where one works and whether or not one works.

The Federal Government has the used its power to make decisions relative to Medicare costs and to enforce those decisions—but providers have shifted enormous charges to the private sector that otherwise would be covered under Medicare. The blame for this waste and inequity is widespread. . .government, business, the medical profession, unions, and consumers of health care. We are all culpable. The cure is penetrating reform which gives everyone access and, provides only necessary quality care at the lowest cost.

As reform occurs, it will mean sacrifices by all segments of the medical treatment chain, providers, payers and users. Because of the depth of the problem and because of the rapid escalation in costs which WILL CONTINUE if we do not intervene, it is paramount that these changes occur as soon as possible. Waiting another three or four years will allow spending to double again and will hurt those who are unprotected.

Given the gravity of our situation, Dayton Hudson is aggressively participating in various coalitions whose purpose is to bring about health care reform. That is, reform which results in quality health care, delivered to ALL Americans, and delivered in the most economical manner.

In the state of Minnesota, we are a principal participant, along with 5 other large employers, in a strategy called the Business Health Care Access Group. Through it, we are developing a proposal to our state legislature on basic health care reform, incorporating standards of quality care and outcomes-based management, over time, providing for access to all Minnesotans, and controlling cost escalation to the annual increase in CPI.

In addition, I am serving as the chairperson on health care reform considerations in the Minnesota Business Partnership. This group has developed principles that we believe should help guide any health care debate. I would be delighted to provide copies of those principles to anyone who may be interested.

Reform at the state level in Minnesota may well be underway during this legislative year. Even so, we believe that nationwide reform is essential.

We are a national economy. Employers and medical providers alike operate across state lines. We have a mobile population with millions moving annually from state to state. The need for universal coverage will be met only if there is national reform. If 50 states form 50 separate systems, we will have even greater chaos then we have now.

We are so convinced that a nationwide reform is essential that we are members of . . . the National Leadership Coalition for Health Care Reform. For over one year, that coalition has been deeply involved in developing a proposed strategy for universal coverage and major reform.

The American College of Physicians is working with us, as are other major medical institutions . . . The Association of Academic Health Centers, The American Academy of Pediatrics, and The American Nurses Association. Our group also includes about 35 of the largest U.S. corporations (AT&T . . . Ford . . . DuPont . . . GE . . . 3M . . . all regional Bells . . . IBM . . . Kodak . . . Xerox . . . Westinghouse . . . Wal-Mart and Dayton Hudson among them); nine of the largest labor unions, the nation's largest consumer groups (AARP, the United Way, and the U.S. Catholic Conference); all working together and representing over 100 million Americans to achieve systematic reform.

Although we are still in the process of developing our strategy, I can tell you that it will contain both competitive and regulatory elements, including strong financial and tax incentives, to create and utilize comprehensive delivery systems that will compete on the basis of quality, efficiency and price.

We will emphasize wellness and prevention. There will be strong cost containment provisions, limiting payment to scientifically appropriate care. We will propose a system of technology assessment, standards setting, and quality assurance; building further on current efforts of Medicare.

We also will recommend policies which will stop cost shifting between government and the private sector, and within the private sector. There will be recommendations for insurance reform, including the elimination of medical underwriting and

the requirement of community rating for small groups, so that small business is more fairly treated.

There will be strong proposals for malpractice reform and administrative simplification of the system. We believe, because of the nature of our particular coalition, we have a chance to mobilize the private sector and to work with government to achieve these necessary reforms.

We recognize the difficulty that government always has in dealing with a society as diverse as ours. We are dedicated to help bring our government, at the Federal and State levels, and the private sector together around this task.

I urge you to become equally committed to make reform and access a top priority. The problem will not go away. A solution is within our reach, and we are eager to help in any way we can. We look forward to the opportunity.

PREPARED STATEMENT OF SENATOR GEORGE J. MITCHELL

I commend Chairman Bentsen for scheduling this hearing today to examine the rapidly rising cost of health care and the problem in assuring that all Americans have access to care.

Access to affordable, quality health care should be a right for all Americans. But as we are well aware, not all Americans have access to such care.

Most of us believe that the American health care system is the best in the world—for those who can afford it. But the rapidly rising cost of health care is jeopardizing the very foundation of our nation's health care system for all Americans, regardless of income. We must find a way to bring health care costs under control or we risk adding millions more to the rolls of the uninsured.

And in spite of the amount of GNP spent on health care and our nation's advances in medical treatment and technology, our health outcomes are lacking. The United States has one of the worst infant mortality rates in the industrialized world and has, in the last decade failed to immunize all of its children from preventable disease.

We must find a way to provide quality health care for all American citizens. Today that challenge is shaped by two factors: cost and demographics.

The statistics are well-known to everyone here. Thirty-seven million Americans have no health insurance coverage of any kind, generally because they can't afford the premiums. Two-thirds of them are working people and their dependents—people whose jobs do not provide what was once considered a routine benefit, health insurance.

One-third of those without health insurance coverage are children. If we ignore the health care of our children now, it will cost us more to deal with the effects later.

It is not enough that we find a way to add those who are uninsured to the existing health care system. We must make fundamental reform in that system including effective cost containment efforts and insurance market reform.

I believe we must build upon the existing public—private partnership which asks employers to share the responsibility of providing access to health care for their employees and their dependents.

Currently that burden is not shared equitably by all employers. A significant number of large businesses who offer health insurance to their employees are now actively promoting health care reform. Large companies like Chrysler and other major corporations provide a disproportionate share of health care coverage in the business community.

While it is difficult for small businesses to provide health coverage to their employees and their dependents, most already do so. Health Insurance coverage is offered by 80% of businesses with 25 or fewer employees; coverage is offered in 46% of businesses with 10 or fewer employees.

Unfortunately it has become more difficult and more expensive for small business to cover their employees. If we are going to expect small business to provide health coverage to their employees, we must make it more affordable do so.

That is why we must have reform in the small group insurance market. We must stop the practice of "churning"—where small businesses are changing health care plans each year in a desperate search for more affordable coverage.

We must significantly reduce medical underwriting in the small group market so that the illness of one employee does not prohibit the employee or the entire group from purchasing insurance.

But most importantly, we must make health care insurance plans more affordable by controlling the rapid increases in the cost of health care throughout the system.

The high and rapidly rising costs of health care threaten access to quality care for all Americans. In 1980, 11% of the Federal budget was spent on health care. The Congressional Budget Office projects that health spending will be nearly 20% by 1996.

Over the last decade a variety of cost containment strategies have been attempted by both the government and private sectors. These strategies have had mixed results, but overall there appears to have been little impact on the growth in total health spending. Clearly, we must evaluate these cost containment strategies and seek additional ones. It is important that we look at the entire health care system—at both the price and volume of services. In the past, controlling costs in one segment of the health care market has often meant cost shifting to other payers.

Health policy in the United States for the past decade has been driven primarily by cost considerations. But cost cutting alone does not constitute health policy. We as a nation need to make explicit decisions about what we want to pay for.

We must assure that each dollar spent gives us its best return. I believe that we can get more value for the over six hundred billion dollars we spend each year on health care.

It is estimated that between 10 to 30 percent of treatment for illnesses provided by physicians is either unnecessary or ineffective.

We believe that the outcomes research initiatives being conducted through the Agency for Health Care Policy and Research, will improve the quality of care while reducing or eliminating unnecessary or ineffective treatments. We must also evaluate new and existing technology in the same way if we are going to control the rapidly escalating costs of MRIs, CT Scans, and other revolutionary technologies in medicine.

Consumers too, must play a part—consumer demand is part of the cost problem. Consumers cannot demand the latest in medical technology when it may not be necessary to diagnose or treat their illness. Clearly, both patients and providers must change their behavior if this nation is going to control unnecessary health care costs.

The Federal and State governments must share the burden in reforming the health care system. Even under the best case scenario, not all Americans will have access to employer-based health insurance.

We must reform and expand the public system. This may ultimately result in a significant reform of the Medicaid program—or the development of a new program.

Many of the States, including Maine, have been innovators in health care reform. Congress should look to the States to determine whether some of those innovative programs might be appropriately expanded on a national level.

The Congress must begin to focus on comprehensive reform of the health care system. We must look beyond the immediate crisis of budget cuts in health care programs toward restructuring our health care system in a way which will provide services to all who need them while controlling the rapidly escalating costs of health care.

I look forward to hearing from our distinguished witnesses here today and to working with them and others to control the rapidly rising costs of health care and assuring that none of our citizens are without access to quality health care services.

Prepared Statement of John C. Morley

I am John C. Morley, President and CEO of Reliance Electric Company. Reliance Electric is a Fortune 300 company headquartered in Cleveland. We compete in industrial and telecommunications markets worldwide, with annual sales of $1.5 billion. Reliance has nearly 13,000 employees in the U.S., and over 14,000 employees worldwide. We have 26 manufacturing facilities in the United States and 16 overseas.

As additional background, I serve the Greater Cleveland Health Quality Choice Coalition as chairman of the Purchaser CEO Leadership Group and of the Coalition Steering Committee. I am also Vice Chairman of the Board of Trustees of University Hospitals of Cleveland, a trustee of Case Western Reserve University, and a member of the Visiting Committee of the School of Medicine at CWRU.

With me today are Powell Woods, Vice President of Human Resources for Nestle Enterprises, and Charles Weller, an attorney with Jones, Day, Reavis & Pogue.

I am pleased to address one of today's most important and challenging subjects—health care. The basic issues, as I see them, are access to health care, the quality of health care, and the cost of health care.

There are three points I'd like to make in my opening remarks:

1. In the United States, we have developed the wrong incentives for health care cost reimbursement. We pay for the quantity of care delivered, not the quality. We must address our fundamental problem—the pay-for-service system of reimbursement. The new direction I suggest is a patient choice system that rewards doctors and hospitals for quality, efficiency and results.
2. My experience with the Cleveland Health Quality Choice program convinces me that we can make the change to a market-based, patient choice system.
3. I believe the private sector is interested in working with Congress in a public/private partnership to pursue these new directions in addressing our access, quality and cost issues.

Before I elaborate on these points, let me say that I realize that when a businessman discusses health care, people immediately assume that he is going to focus on cost and the need to save money for his company.

Let me address this issue right now! Health care expenditures are the fastest growing cost at Reliance Electric. I am vitally interested in controlling them. Next to steel, they were the Company's largest buy last year. This year they will exceed steel. I am also vitally interested in controlling these costs because of their impact on employees, retirees and their families. Today, 15% of the average American worker's total compensation goes to pay for health care, versus only 3% in 1965.

But I am not just interested in cost. In fact, I am more concerned about quality. I would argue that a proper emphasis on quality can lead the way to lower costs. Let me explain why.

I see two fundamental weaknesses in our current health care delivery system.

Number one—the patient (and the purchasers) have very little information on the relative quality of health care providers. When we need surgery or some other treatment, we don't have hard evidence as to which providers excel in the required procedure. Nor do we have much information on the efficacy—or alternatives to—the procedure or treatment itself.

Number two—the pay-for-service reimbursement system punishes, rather than rewards, quality, efficiency and results. Currently, most doctors and hospitals are rewarded for high volume and inefficiency, and punished for effectiveness and efficiency by the pay-for-service system of financing health care.

As Senator Mitchell incisively stated:

> "In decisions made regarding health care in our society, the driving force is not what the patient wants, not what the patient needs most, not what is the least expensive method for meeting the patient's needs. Rather, the driving force is what is or is not reimbursable under an insurance program."

Put bluntly, we pay the medical community for what they do *to* patients, not for what they do for patients.

Data from the medical community itself paints the picture of a society burdened by the extreme over-practice of medicine, with no standard measures of quality in health care, no accessible means to determine the efficacy of procedures, and no mechanism or incentives working to improve value to patients. Based on this data, we believe that such a quality-based, competitive delivery system, with proper incentives furnished by private payers—and ultimately government payers as well—can produce efficiency or productivity gains in the health care system on the order of 20–30%. A 10% savings alone would yield $75 billion in savings annually.

By rewarding quality and efficiency, we can improve quality, reduce cost, and use the savings to pay for the improved access of millions of Americans to quality health care. The opportunity is substantial, because the pay-for-service system accounts for about 85% of all public and private payments to doctors and hospitals.

The key to the quality, access and cost dilemma is to change the pay-for-service system to a system of reimbursement that rewards quality and efficiency in response to informed patient choice.

Can this be done? My experience with Cleveland Health Quality Choice and at Reliance Electric Company convinces me that yes, it can.

Greater Cleveland Health Quality Choice is a private sector initiative that was first announced at the Pepper Commission hearings in Cleveland in 1989. It is a purchaser-led collaborative effort to drive productivity gains by making quality and efficiency the focus of our purchasing system.

Cleveland Health Quality Choice involves one of the most talented and committed groups of people I have had the pleasure of working with in my professional career. The people making this program work are uniquely dedicated to a common purpose: to work together on a voluntary basis to create uniform measures of hospital quality that purchasers can use to encourage patient choice of high quality, cost-efficient

procedures. The system is designed to reward quality and efficiency with a larger share of the patient market.

That all sounds great in theory, but translating a sound philosophy into productive programs that produce tangible and measurable results is hard work. Let me describe what we've done.

The CEOs of Cleveland Tomorrow, an organization of fifty of the largest local corporations, combined with the Council of Smaller Enterprises (a coalition of small businesses) to form a purchasers' leadership group. This large business/small business combination represents over 350,000 covered lives in Cleveland alone.

There are two working committees:

First, the Systems Advisory Committee, comprised primarily of physicians and hospital representatives, has developed a severity-adjusted clinical outcome measurement system, a patient evaluation of care measurement system and a formal data feedback loop for providers.

All hospitals in the Cleveland area have agreed to measure themselves under a common set of quality indicators. These indicators include patient outcomes—adjusted for severity of illness—and patient evaluations of the quality of hospital services. Thus, both clinical quality and service quality will be measured. The data will be released to purchasers for use in 1992.

Second, the Incentive Benefits Committee, comprised of benefits experts from leading Cleveland companies along with representatives from the provider community, is developing a program to marry the output of the quality measurement systems with employee health benefit plans designed to create the incentives for employees to choose the demonstrated quality providers.

We have a Communication/Education Committee that is actively communicating and promoting the project with all interested audiences, including organized labor.

We have recently completed a survey of how many Cleveland employee health plans are changing from pay-for-service to patient choice incentive plans. As I1m sure you can appreciate, changing the pay-for-service system of reimbursement is not easy. We surveyed the 11 largest Cleveland companies and the COSE program for small employers, which, together, provide health benefits to over 250,000 Clevelanders.

I am pleased to report two important findings. First, all 12 organizations have either already implemented, or are likely to implement next year, some type of patient choice incentive plan. Thus, many Cleveland employee health benefit plans will be ready to use the Cleveland Health Quality Choice data as soon as it becomes available.

Second, 11 of these 12 organizations are national in scope and provide health benefits to over 1.5 million people nationwide. We anticipate a multiplier effect that will benefit all of these people as the principles of Cleveland Health Quality Choice are carried to other communities.

Cleveland Health Quality Choice convinces me that market reform can work, and that the change from pay-for-service to patient choice can be made.

Reliance Electric's health plans provide coverage for more than 40,000 people. This year, our health plans for employees, retirees and their families will cost $50 million. That is the same amount as our total net earnings in 1990. It is also $10 million more than our total capital expenditures of $40 million.

Another important dimension of health care costs to Reliance and its employees is FASB. The anticipated FASB present value of Reliance's health and life insurance benefits is $85 million. The FASB rules for retiree health benefits will make it even more challenging for companies to provide health benefits.

These high health care costs directly affect our competitiveness in world markets. Briefly, America spends twice as much as Japan on health care, and 50% more than any other major country. These higher costs, relative to other countries, make it harder for American workers and companies to compete effectively in world markets. With lower proportionate spending on health care, most other industrial countries invest a much higher proportion of their resources in new manufacturing plant and equipment. For example, Japan, with a manufacturing sector about 60% of the size of that of the United States, invested *more* in plant and equipment in 1989 than did the United States.

Manufactured products account for 75% of all U.S. exports. If American companies continue to spend a disproportionate amount on health care costs relative to our worldwide competitors, we will be at an increasing competitive disadvantage.

At Reliance, health care costs have been rising faster than the CPI. As a result, we made two basic changes to our health plans in recent years. The first type of changes included preadmission review, medical case management and some increased employee cost-sharing.

The second basic change was the adoption of a Preferred Provider Organization network of doctors and hospitals nationwide, effective January 1st of this year. At the present time, nearly 50% of Reliance's covered population is included in the PPO. Employees and dependents will be included as local panels of doctors and hospitals become available, subject to applicable collective bargaining agreements. As positive as these steps have been, none offers the potential for quality and efficiency as CHQC.

In conclusion, I am optimistic about the new directions taken by the private sector in fundamental health care reform, as illustrated by Greater Cleveland Health Quality Choice. With the growing involvement of private enterprise, I believe we can achieve the multiple goals of improved quality, greater access to health care services for the uninsured, and cost control.

I also believe, as I mentioned at the outset, that the private sector is interested in working with Congress in a public/private partnership to pursue these new directions in addressing our access, quality and cost issues. I have four specific recommendations I urge you to consider.

1. *Quality Measurement Research.* I encourage you to continue the innovative and important funding of quality measurement research that you are doing.

2. *Incorporate Private Sector Reforms in Public Programs.* In Cleveland and elsewhere there are major innovations being made in employee health benefit plans. The expected productivity improvements should make it possible for public purchasers like Medicare and Medicaid to begin "buying in" to a reformed health care market on behalf of the poor and the uninsured.

3. *Medicare and Employer Groups.* It is not widely known that about ⅓ of all Medicare beneficiaries—10 million people—have Medicare Supplement benefits through employer health plans. As employer health plans change from the pay-for-service system to the patient choice system, I believe that through a public/private partnership we can find ways to extend the benefits of these changes to the Medicare program as well.

4. *The Patient Choice Small Employer Purchasing Group Act.* We have developed proposed Federal legislation we believe can significantly help reduce the number of uninsured Americans, without requiring any government funds: the Patient Choice Small Employer Purchasing Group Act. It is intended to stimulate the formation of private Small Employer Purchasing Groups, like the Council of Smaller Enterprises of the Greater Cleveland Growth Association program, which makes health insurance available to 10,000 small employers in behalf of over 125,000 employees and their dependents.

I welcome any questions you might have.

RELIANCE ELECTRIC COMPANY

- Fortune 300 company headquartered in Cleveland, Ohio
- Worldwide sales of $1.5 billion
- Industrial products and services include:
  - electrical motors and controls
  - mechanical power transmission equipment, such as gear reducers and mounted bearings
  - electric power transformers used by electric utilities
- Telecommunications products and services include:
  - power and transmission systems
  - connection, protection and distribution devices
- 26 manufacturing facilities in the U.S.; 16 overseas
- 1990 earnings from continuing operations: $50 million
- 1990 capital expenditures: $40 million
- 1991 health plan costs: $50 million
- Covered U.S. Population: 42,000 people;
  12,800 employees; 2,800 retirees; 26,400 dependents
- Type of Plan: Switched from traditional pay-for-service plan to point-of-service PPO nationwide January 1, 1991

GREATER CLEVELAND HEALTH QUALITY CHOICE COALITION CEO LEADERSHIP GROUP

John C. Morley, Chairman, Reliance Electric Company
Edward F. Bell, Ohio Bell Telephone Company
James M. Bigger, Nestle Enterprises, Inc.
John G. Breen, Sherwin-Williams Company
John B. Hexter, Hexter & Associates

David H. Hoag, LTV Steel Company
Frank E. Mosier, BP America
John D. Opie, General Electric Company
Patrick S. Parker, Parker Hannifin Corporation
Richard W. Pogue, Jones, Day, Reavis & Pogue

THE RANGE OF OPPORTUNITY FOR PRODUCTIVITY IMPROVEMENT

Eugene Robin, M.D., Stanford University:

"America's . . . annual healthcare bill could be cut by 30 percent . . . if unnecessary medical and surgical tests, treatments, and procedures were discontinued."

David Eddy, M.D., Duke University:

"We are wasting from 10% to 30% of our resources . . . in terms of doing things that are either not worthwhile at all or are relatively inefficient compared to other things we might do."

Arnold Relman, M.D., New England Journal of Medicine:

"I have long held the opinion, based on wide experience as a consultant and teacher in internal medicine, that more prudent choices by physicians could probably reduce expenditures for drugs, tests, procedures, and the use of hospital facilities by at least 15 to 20 percent—without any loss of medical effectiveness. Lack of available information about the relative effectiveness of new technology and inadequate education of practitioners are partly to blame for this overutilization of medical resources, but the economic inducements of an insurance-based, fee-for-service reimbursement system surely play an important role."

MEDICAL COMMUNITY VIEWS ON PRODUCTIVITY OPPORTUNITIES

• 20–30% of all medical procedures, done even in good hospitals, are not worthwhile

ARNOLD RELMAN, *Editor, New England Journal of Medicine.*

• 30% of all carotid endarterectomies are needless
• 20% of all angioplasties are unnecessary

NEW ENGLAND JOURNAL OF MEDICINE.

• ½ of the 200,000 coronary bypass operations performed annually should not be performed . . . risks outweigh benefits
• 90% of all hysterectomies are needless

EUGENE ROBIN, *Stanford Medical School.*

• 23% of hospital admissions were unnecessary
• 17% of hospital admissions were avoidable with ambulatory surgery

RAND CORPORATION STUDY.

THE PATIENT CHOICE SMALL EMPLOYER PURCHASING GROUP ACT

The Patient Choice Small Employer Purchasing Group Act is proposed Federal legislation developed by Cleveland employers through the Health Policy Coalition to significantly reduce the number of uninsured Americans—without requiring any government funds.

The unavailability of affordable health insurance to small employers is a major reason why there are so many uninsured Americans. Approximately 70% of the uninsured are either employed or dependents of employees, and most of the employees work for small employers. The Act would:

1. Facilitate the formation of private Small Employer Purchasing Groups, like the Council of Smaller Enterprises of the Greater Cleveland Growth Association ("COSE") program. The COSE program is a purchasing group that makes health insurance available and affordable to 10,000 small employers and over 120,000 employees and their dependents. Fully 25% of COSE small employers started providing health insurance because COSE made coverage affordable.

2. Use as a model for small employer health insurance the Federal Liability and Risk Retention Act of 1986, which has been successful in making liability insurance more available and affordable.

3. Redirect state premium taxes for newly covered groups, which range up to 4%, to help purchase reinsurance. Only newly covered groups would be entitled to the waiver, so that the waiver will not reduce existing state tax revenues.

4. Allow patients to choose the combination of benefits that best meet their needs through small employer purchasing groups without regard to state or federally mandated benefit laws, like patients affiliated with most large employers can do under ERISA.

5. Private funding reinsurance to reduce pre-existing condition restrictions and provide "stop loss" coverage by charging Group members approximately the amount of state premium taxes.

Prepared Statement of Michael Peevey

Mr. Chairman and Members of the Committee: My name is Michael Peevey. I am president of the Southern California Edison Company and I am accompanied today by Dr. Jacque Sokolov, our vice president and medical director. Southern California Edison is the nation's second-largest electric utility, providing service to four million customers in a 50,000-square-mile territory in Central and Southern California.

I appreciate the opportunity to testify today on the critical need for reform of our nation's health care system. Edison is heavily involved in both providing and paying for health services for our 55,000 employees, retirees, and their family members. Since 1903 we have operated primary health care services in house, which today include eight primary care clinics, two first aid stations, and a large corporate pharmacy. In 1990, there were more than 100,000 patient visits in our clinics and 250,000 prescriptions processed in our pharmacy. We also self-fund and self-administer our own health plans, including the processing of all medical claims.

I am here today to ask for your help in developing a Federal policy aimed at managing the growth in national health care spending. As a member of the National Leadership Coalition for Health Care Reform, the Washington Business Group on Health, and the Alliance of Business for Cost Containment, Edison is working actively to encourage a Federal response to the issue of escalating health care costs. Many of you may think that the corporations in these groups advocating national reform do so because they are either unwilling or unable to control their own costs. For Edison it is quite the opposite, instead our position evolves from our success in controlling our health care costs. This process has left us with a clear vision of the need for national reform.

Today, I would like to answer three questions for you: why is Edison concerned about the nation's health care system, what have we been doing about it at Edison, and what would we like the Federal Government to do about it?

Edison's Concerns About Health Care

From our perspective, the financing of health care in the United States is out of control. We have the most expensive and the least accessible health care services of any industrialized nation, and we pay for it with the most fragmented, complicated, and intrusive financing scheme ever invented. This financing scheme and the turmoil it creates for both providers and purchasers is threatening the viability of health care services in our communities.

Financial Turmoil Puts Us All at Risk

As employers and responsible members of our community, we must be concerned that the availability and quality of health care are deteriorating. The phenomenon of 5 million Californians—one out of every six—without health insurance and at risk for massive medical expenses has eroded the sense of security in all Californians. The withdrawal of half of the Los Angeles area trauma hospitals from the trauma care system due to unbearable levels of bad debt and charity care in emergency rooms has put all of us at risk, regardless of our personal health insurance coverage.

Our Health Plan Costs are Rising

This growing chaos in our health care system and its effect on Edison's ability to control its own health benefits program is a most unsettling predicament. The decade of the eighties was a time of awakening to the issue of health care costs for most employers. With medical prices rising two to three times as fast as other

prices, and employers' health plan costs outpacing medical inflation, health benefits have become a significant aspect of labor costs. Twenty five years ago, when the annual bill for health benefits equaled about 9% of the average company's pre-tax profits, few top executives paid much attention to it. Today, with the health bill equal to about half of pre-tax profits, few top executives can afford to ignore it.

Our numbers at Edison are not atypical. In 1981, we paid a total of $21 million for our health program. By 1990, the program's costs had more than quadrupled to $88 million. None of our experiences in the 1970s prepared us for the acceleration of our costs in the 1980s. Toward the end of the eighties, our costs were rising at a rate of 23% per year. A rate of increase that high would have been difficult to justify in our rate case filing with the California Public Utilities Commission. It also had a detrimental impact on Edison's competitive position during a period of increasing deregulation of the utility industry.

We had to act. In 1989, we implemented a series of innovative health management strategies creating one of the first corporate managed health care plans in America. Our efforts bore fruit: in 1989 we saw no increase in our health care costs over 1988, and we think we have brought our long-term trend rate down to the 10–12% range. Not a bad trend rate when you look at what other employers are experiencing. Nonetheless, our current rate of increase is still high enough to double our costs every six years, and to increase them threefold by the end of this decade. As successful as we have been, health care costs continue to represent an ever-greater portion of our overall cost structure.

UNPREDICTABLE COSTS MAKE FINANCING UNCERTAIN

It is not just the rate of growth that is troubling, it is also the unpredictability of that rate. The uncertainty of health care inflation in the past with our active worker plans may not have been significant. Let me assure you that we are victims of this uncertainty now that we must project our retiree health liabilities. The Financial Accounting Standards Board's (FASB's) recent statement on post-retirement benefits, requiring that we add net liabilities for future retiree health benefits to our corporate balance sheets, is forcing us to peer into a murky and frightening future. Projecting costs three or four decades hence, based only on current medical practice, financial responsibilities and medical inflation, creates astronomical liabilities for companies with older work forces and may significantly affect the financial positions of these firms. Add into the projection the health care changes we are experiencing today—rapid growth in technology, periodic cuts in Medicare, and accelerating rates of inflation—and even Edison's future retiree health costs could become catastrophic. The new FASB standard makes the consequences of uncertainty palpable to us and sharpens our focus on the need to manage our health care costs.

Individual Efforts Cannot Control Costs

What concerns me is that at Edison we have worked hard to manage our health plans, yet we have discovered the limits to our power to influence health care costs. We have hired our own physicians, operated internal clinics and a pharmacy, and developed a preferred provider network with negotiated discounts. Yet our costs continue to rise at a significant rate because, in reality, our efforts can influence only a small part of a large system. While we are carefully managing our resources, governments are cutting their Medicare and Medicaid payments to hospitals, forcing hospitals to raise their charges to us. At the same time, providers are responding to an increasingly competitive marketplace by building new facilities or purchasing new diagnostic equipment and passing these costs along to us.

The irony is that we are trying to manage a nationwide problem of rising health expenditures with only isolated individual efforts. You have the same problem in Medicare that we have in our health plans, yet all of us operate as though we need only shift our costs to someone else to solve the problem. Then, of course, we wonder why we see the same problem year after year. It is as if living on the banks of a river with the floods coming each spring, we went out and sandbagged only our own riverfront, and then wondered why our property was under water. Of course, if our problem was flooding we would not hesitate to get together and organize a flood control project. For some reason, with health care inflation we are content to let everyone try to bail their own water.

EDISON'S COST MANAGEMENT EXPERIENCE

Edison has been only too willing in the past to take action on our own to deal with this problem. As I mentioned briefly earlier, in 1989, we responded to our health care cost problem with a major effort to restructure our own health care

plans. This reform was aimed at encouraging our employees to take more responsibility for their health, developing financial incentives for the use of efficient, high quality providers, and managing utilization to minimize unnecessary, inappropriate and harmful health care. We feel this program has worked very well. Let me explain what we have done.

Incentives for Efficient Use of Care

First, we created financial incentives for participants to use health care efficiently. We have done this through a combination of new cost sharing options in HealthFlex, our indemnity plan, and flexible contributions to a health care reimbursement account. HealthFlex offers a choice of three deductible options and minimizes copayments for employees who use the 7500 physicians and 85 hospitals in our preferred-provider network. We also created our own self-funded HMO option to provide a lower-cost alternative to our employees.

Incentives to Reduce Health Risks

Second, we encourage our employees to reduce their own health risks through two financial incentives: a preventive health account that provides $100 toward the use of preventive services, and a Good Health Rebate that provides cash incentives for employees who maintain healthy lifestyles or reduce their risk factors.

Management of Health Care Utilization

Third, we focused our utilization management efforts on helping participants get necessary and appropriate care in several key areas: hospitalization, outpatient surgery, mental health services and substance abuse treatments; and we initiated a five-year effort to phase in managed care and cost sharing features for future retirees as well.

Results

In short, at Edison, we set out to involve our employees in the management of our health care costs—and our efforts are paying off. In a two year period—1989 and 1990—we spent approximately $38 million less than if we had not implemented these programs. We brought nearly all of our employees into one of two low-cost health plans—either the HealthFlex plan which now enrolls 74% of our employees, or our self-funded HMO option which covers 13% of our employees—at a savings of $14 million for 1989 and 1990 over the anticipated expenditures. We achieved a high rate of screening, counseling, and behavior change in our preventive health efforts. We actively manage our inpatient admissions and outpatient services, for a savings of $19 million over our expected costs for 1989 and 1990.

While we have developed a good program that will produce continued cost savings over the years, we still are dealing with only one aspect of the broader cost-containment problem—controlling individual utilization of health services. When we look at all the other factors contributing to this problem, we recognize that we cannot change them by ourselves. It must be a united effort.

EDISON'S REQUEST TO THE FEDERAL GOVERNMENT

Managing systemwide health care costs is more than any of us can do individually—it requires a partnership between the private and public sectors. We are committed to providing health care to our employees and managing their utilization of health services. From the Federal government we need greater control over the external factors that raise our health care costs. We need to know that our cost increases will be predictable and that higher-dollar expenditures are buying better care.

An End to Cost-Shifting

The first thing we would like to see is an end to cost shifting. Medicaid cuts, negotiated discounts and the rise in uncompensated care are forcing providers to dramatically increase charges to other third-party payors. Cost shifting not only causes small employers' costs to soar, it also contributes to an overall acceleration of provider charges and a growing confusion about who is paying for what.

At the root of cost shifting are inadequate Medicare and Medicaid payments. The dilemma for the Congress is that to pay fairly for Medicaid and Medicare beneficiaries will require additional revenue. Edison would rather pay health care costs for the poor and elderly through broad-based and equitable taxes than through the hidden charge we now have on our health plans.

Merely paying more to providers to serve government beneficiaries will not by itself improve the stability of health care financing. Edison believes that the Federal government should create a system of all-payor rate negotiation to ensure that

every health care payor, no matter how small, can benefit from the low rates negotiated by the largest purchasers. Only through an all-payor approach can we be assured that no one payor can control their costs merely by dumping their expenses in someone else's lap.

A Limit on National Expenditures

While uniform rates may eliminate inequities and stabilize financing, they do not prevent excessive utilization of health services from driving up national expenditures. To develop certainty and predictability in health care financing, Edison believes an overall limit should be set on increases in total expenditures—a national expenditure target. A national target will give us all a yardstick for measuring our progress toward cost containment, and it will provide some modest reassurance to employers that there is some limit to their health care spending.

A Limit on Capital Expenditures

In the end, however, much of this effort will be futile unless we also constrain the endlessly increasing supply of health care. In most industries, increasing supply tends to reduce prices—in health care the opposite is true. Hospital profits rose in the 1980s while an increasing proportion of hospital beds were empty. An oversupply of physicians, predicted to lower physician incomes in the eighties, instead produced more services. An explosion in new diagnostic technologies added hosts of new medical procedures rather than replacing older less efficient methods.

While the Heath Care Financing Administration's efforts to limit excessive Medicare payments for new capital and technology are to be applauded, they should not be confined to the government. All payors need to be represented in the effort to reduce excess hospital capacity and efficiently allocate new technology, if these efforts are to be truly effective.

Greater Value from Health Care Spending

Finally, we need to be assured that we are getting a dollar's worth of health care for a dollar's worth of cost. Edison is willing to manage its health programs to avoid unnecessary and inappropriate care and encourage the highest quality of medical care. We need the leadership of the Federal Government to generously fund outcomes research, encourage the development of medical practice standards, and ensure that payors remain free to identify, contract with, and reward providers who can deliver appropriate, high quality medical care.

Begin with the Building Blocks

The prospect of another decade of rapid acceleration in health care costs is not a cheerful one for the business community. Yet, it is unlikely that Congress can act quickly on comprehensive reform, and even if it could, initiatives begun today would have little chance of slowing the growth in expenditures for several years.

While a comprehensive program to control health care spending cannot be developed overnight—it is important to make a start; and I believe no matter which reform approach you prefer, all reforms will have to start at pretty much the same place. To become knowledgeable purchasers at the local level or the Federal level, as individual payors or as part of an all-payor system, we will have the same needs for information. For this reason, I would like to recommend six "building blocks" of Federal policy that Edison believes should be laid as a foundation for comprehensive reform. They are:

(1) A National Council on Health Care that would monitor national and state-level health care expenditures, propose non-enforceable expenditure targets, and report annually to the Congress on causes of expenditure growth and proposed solutions;

(2) A single national health care claims form that would be used by all third-party payors, could be entered into an electronic claims system, and could generate statistical records for a national health care data base;

(3) A national data base on significant provider capital purchases to support statistics on the allocation of new capital and technology;

(4) A national technology assessment agency with responsibility for determining the efficacy of new procedures and equipment, and publishing coverage guidelines for insurers;

(5) Medicare/Medicaid waivers to permit states to adopt all-payor systems, with a multiyear transition and additional Federal financial support to adjust government payments to private-sector payor rates.

(6) Waivers of Federal antitrust restrictions on community multipayor consortiums to permit group negotiations with physician and hospital groups.

We believe these "building blocks" would be neither controversial nor costly, and would pave the way for developing the comprehensive reform we hope will follow.

Conclusion

In conclusion, I am concerned with the vision I have of our health care program a decade from now. At our current long-term growth rate, Edison's health care budget will have increased three to four times by then. While we certainly plan to continue providing excellent health care benefits to our employees in the next century, we have no desire to become a health care company in the process.

We urgently need from Congress a sense of how this nation is going to deal with the problem of rising health care costs. Employers need to see the light at the end of the tunnel and know there is a limit to the role you expect us to play in financing health care in the future. We do not ask that Medicaid immediately pay its fair share of health costs, or that the uninsured be covered at once. We do urge you to adopt a strategy that will assure us we are moving toward fair payment and universal coverage. We do not ask that you set expenditure caps or health care budgets immediately. We do urge you to commit the resources to a national data base so that national health care accounting and expenditure targets can become reality. We *do not* ask that you halt the flood of new technology or the expansion of health care facilities in the near term. We do urge you to adopt a convincing strategy to lead us toward a more rational allocation of our health care resources.

What is missing in health care today is a sense of direction. We have seen an abundance of Brownian Motion on health care with no policy to manage our resources or solve our difficult problems. What we need most from the Federal government today is the courage to set a clear course for the future. A future that will bring about predictability and manageability and help us work together to ensure the good health of the nation.

Prepared Statement of Senator David Pryor

[April 9, 1991]

Mr. Chairman, the problems that beset our health care system are seemingly insurmountable. While this morning's hearing will focus on the extraordinary costs associated with our health care system and the over 32 million Americans who cannot afford access to health insurance protection, the lack of protection against costs associated with long-term care and Our unacceptably high infant mortality rates among minorities illustrates that our health care system has many other shortcomings.

One of our biggest problems is that while we can all reach some sort of agreement on the health care problems we face, we have yet to agree on solutions to address them. Mr. Chairman, I commend you for holding this series of hearings on health care costs and access, because I believe they have great potential to bring us closer to a consensus, and ultimately some solutions to the turmoil within our health care system.

According to the Health Care Financing Administration, from 1965 to 1988, health care spending rose from $124 billion to over half a trillion dollars a year. During this time, our per capita spending on health care rose from $606 to $2,124. If current trends continue, experts conservatively estimate that we will be spending, on average, $3,021 a person by the end of the decade.

Normally, when you spend more money on a product, you get something significant back in return. While there is no question that we have the most advanced health care technology in the world, the only people who have access to this care are those who can afford insurance to pay for it. If we don't seriously address the health care cost issue, millions more taxpaying workers will not be able to afford admission to our health care system. As a result, we will see even more people put off basic health services, and seek care in our overused and extraordinarily expensive emergency rooms. We all know that those costs will be underwritten by either the dwindling number of insured people or the taxpayers as a whole.

The Federal Government is paying an ever-increasing share of these health care costs. Federal programs financed nearly 30 percent of personal health care expenditures in 1988, an amount which has been growing steadily over the past several years. Federal spending on Medicare and Medicaid accounted for 10 percent of all Federal expenditures that same year. State and local governments are paying more for health care, too. In 1988, they spent almost $70 billion on health care, which is more than 10 percent of total state and local expenditures.

I often say that Congress waits until it has a crisis on its hands before responding to difficult issues. The day has finally come when everyone—large and small businesses, health care providers, insurers, unions, individuals and their families, and consumer advocates—agrees that our health care system is in a crisis. Unfortunately, while we have universal agreement that we must reform the system, there is no such agreement on how to proceed. Having said this, the lack of consensus and the fact that it will be extraordinarily difficult to reform the system is no excuse for not trying.

At a minimum, I believe we can move immediately to develop, introduce and enact legislation that will provide for substantial insurance market reform. Such legislation would effectively prohibit insurers from discriminating against individuals and small businesses.

In addition, I believe we can take important steps towards containing health care costs. We could reduce billions of dollars a year in unnecessary spending if we effectively addressed the fraud and abuse that is all too prevalent in our health care industry. We could save billions more if we could get a handle on overly burdensome and duplicative paperwork requirements. And where we are overpaying health care providers (and in some cases underpaying others), we must take actions to develop more rational reimbursement systems. As you know, I have already exhibited my willingness to confront the prescription drug manufacturing industry in this area and, where there are other abuses, I will not hesitate to take on other health care providers as well.

Our health care system cannot continue to exist in its present state. I am reassured by the commitment and dedication of the members of the Senate Finance Committee, and I am hopeful that we can work together to rebuild it.

Again, Mr. Chairman, I commend you for convening this hearing and the ones to follow. I look forward to working with you on the monumental, but absolutely essential task of reforming our health care system.

Prepared Statement of Senator David Pryor

[April 16, 1991]

Thank you Mr. Chairman for calling this hearing to focus on the relationship between costs of health care products and services and the ability of the American consumer to pay for them.

Mr. Chairman, as this Committee knows, I have a strong interest in the ability of the American public—especially elderly Americans—to pay for their prescription medications. Year after year in the 1980's, prescription drug costs significantly outpaced the rate of general inflation—in fact, drug prices rose a staggering 152% between 1980 and 1990, while the general inflation rate was only 58%. While many of us thought that the drug industry would heed Congressional warnings to moderate drug price inflation, new data, which I will share with the Committee later, indicate that these warnings have fallen on deaf ears.

Indeed, the high cost of prescription drugs impede the ability of our nation's physicians to treat their patients, especially the elderly. What good are prescription medications when their costs are out of reach to the average American? New cures for Alzheimers and cancer benefit no one if they are unaffordable. Indeed, unreasonably high prescription drug costs have created a public health crisis in this country.

Additionally frustrating is the fact that most other industrialized nations have found a way to control their drug costs through bargaining with the drug companies or using therapeutic formularies. An unusual dichotomy has developed—most of the drugs used by mankind are produced here in the United States, and most drug research is supported by American taxpayers, yet it seems that manufacturers charge some of the highest prices here in the United States.

The truth of the matter is that the more we give the drug industry in terms of tax write-offs and grant subsidies, the higher prices we are charged in the United States. Take for example the Possessions Tax Credit, also known as the 936 tax credit. The credit, which allows companies to reduce their taxes by producing products in Puerto Rico, cost the Treasury $1.4 billion in lost revenues in 1987.

Of all industries in the United States, over 52% of the 936 credit is claimed by drug companies, and it allows the industry to escape 34% of its total tax liability to this country. According to CRS, the cost of the credit is expected to increase to $2.6 billion in 1992. All this, and what do we get in return? High drug prices, which impede access to needed medications.

Mr. Chairman, the time has come for this Committee to reevaluate its policies toward the drug industry. We can no longer allow the drug industry to continue to double-dip into the pockets of the American consumer and taxpayer by charging

high prices for drugs on the one hand, and taking tremendous tax credits on the other. I am eager to hear our witnesses' ideas about this problem, and any proposed solutions they would like to share.

PREPARED STATEMENT OF ROBERT D. REISCHAUER

Mr. Chairman, I appreciate the opportunity to appear before this Committee to discuss the problem of health care costs and the effectiveness of various strategies by which we might hope to achieve greater control over these costs.

Although the United States is a leader in medical research and has the capability to deliver the highest quality health care, criticisms of its health care system have been growing over the past decade. These criticisms have focused on two principal features of our system.

- Spending per person for health care in the United States is very high compared with other industrialized countries, and total national spending for health is increasing more rapidly than national income; and
- Many people in the United States lack financial access to health care—that is, they are uninsured and ineligible for existing public health care programs.

The United States spends much more per capita for health care than other industrialized countries. In 1987, the United States spent 11.2 percent of gross domestic product (GDP) on health care, compared with 8.8 percent in Canada, 8.1 percent in West Germany, 6.8 percent in Japan, and 6.1 percent in the United Kingdom. Moreover, the differential between the United States and other countries' spending on health care as a share of GDP has increased dramatically since 1965. This increase in health spending also has significant implications for the Federal budget. In 1980, 11 percent of the Federal budget went to health care. CBO projects that health spending will be nearly 20 percent of the budget by 1996.

THE HEALTH SECTOR

Many factors contribute to the high and rapidly rising costs of health care per capita, including an aging population and more effective and costly medical technologies that are being developed on a continuing basis. Many observers, however, suggest that a major reason for high and rapidly rising health costs is the failure of the normal discipline of the marketplace to limit the quantity of services supplied, resulting in part from the fact that consumers pay less than the full price of the services they purchase.

In the health services market, the conditions necessary for the existence of a fully competitive market are not met. In particular:

- Uncertainty with respect to the occurrence of illness has led to the development of extensive insurance of a type that encourages consumers to purchase more and higher quality services than they would in the absence of insurance;
- The complexity and rapid technological change in medical services and uncertainty about the efficacy of treatment have led consumers to delegate much decisionmaking to providers; and
- Entry by providers to the industry is severely regulated, knowledge about differences among providers is not commonplace, and in many cases there are few competing sellers.

The role of insurance in the health sector is critical to understanding the imperfections in the market for health services that contribute to high and rapidly rising costs. Thus, the characteristics of these two markets, and recent trends that affect their performance, provide background for the examination of the effectiveness of strategies for controlling costs.

The Market for Health Insurance

In 1990, about 70 percent of the population under the age of 65 had health insurance through some employment-based group. The growth in employment-based health insurance since the 1940s has been influenced by the lower premiums that can be charged for group health insurance compared with those for individual policies. These lower premiums are possible because risks are more predictable for larger groups and because administrative costs are lower as a share of benefits for groups. An additional factor in the growth of employment-based insurance is that employer-paid fringe benefits are excluded from the taxable income of employees. This exclusion will save individuals an estimated $56 billion to $58 billion in Federal, state, and local taxes in 1991.

Although employment continues to be the principal source of health insurance, the availability of employment-based coverage has been reduced by changes in the private insurance market over the past decade. Many of these changes occurred in response to rapid increases in the costs of health care. A related impetus for change was the development of policies intended to control rising health care costs that encouraged competition among health insurers and increased choices of insurance arrangements available to consumers.

First, between 1980 and 1990, enrollment in health maintenance organizations (HMOs)—that is, combined insurance-service delivery systems—has risen nearly fourfold to 35 million people. HMOs offer a defined network of providers to their members, and are able to exert substantial control over the practice patterns of these providers. As a result, they have the potential to provide comprehensive health services for lower premiums than those of traditional insurers.

Second, traditional insurers have moved away from community rating, using experience rating instead. Under community rating, premiums are based upon the expected costs per person of providing insurance in a geographic area, averaged over the entire insured population. When experience rating is used, insurers base the premium for a given group on the average expected costs of insuring that group alone. Experience-rated premiums are lower—relative to community-rated premiums—for groups that are expected to have fewer health problems than the average in the community. The other side of the coin, however, is that premiums are higher for those that are expected to have more health problems than average, compared with community-rated premiums.

Third, rapid increases in the cost of health care have also affected the level of premiums for health insurance. Between 1977 and 1987, the average real premium paid by employers rose from $1,111 to $1,656 (in 1987 dollars), or by 49 percent. Because the costs of health insurance are a larger share of compensation for lower-wage workers, the dramatic rise in premiums has reduced employment-based coverage for them more than for higher-wage workers.

The Market for Health Services

Several characteristics of the market for health services are important in explaining the level and trends in health spending. One change that has affected the market is the increase in the supply of physicians relative to the population over the past two decades—from 1.6 per 1,000 population in 1970 to 2.4 per 1,000 in 1990. The availability of more physicians has improved access to health services in areas that were previously less well served and has made physicians more willing to participate in managed care arrangements and to negotiate discounts on prices.

Since physicians can influence the demand for medical services, however, the greater prevalence of negotiated discounts has not resulted in a decline in physicians' incomes. Instead, as prices have been constrained, the volume of services provided has risen. This increase may have resulted, in part, because consumers are likely to want more at the lower price, but it also resulted because physicians can increase the number of services they provide or change the way in which their services are counted or billed. Evidence from the experience under Medicare indicates that, when prices decline, the volume of services increases sufficiently to offset about half of the potential reduction in spending that would otherwise have resulted from the price decrease.

In addition, some analysts believe that rapid technological change explains a significant portion of the increase in real health care spending per capita that has occurred over the past two decades. The present financing system for health care encourages the rapid dissemination of new technologies—access is available quickly for those with insurance or who can afford to pay directly—but excess capacity can easily develop. Excess capacity can then lead to overuse of these technologies, with higher costs resulting and with potential for harm to patients because of side effects or other complications associated with medical interventions.

The market for health services has also been influenced by the continuous decline over time in the out-of-pocket costs for health services paid by consumers. Although consumers partially pay for their health services through insurance premiums, taxes, and lower direct wages, their decision to use a specific health service is influenced by the direct out-of-pocket cost for that additional service. The decline in the proportion of costs paid out of pocket—from 46 percent in 1965 to 23 percent in 1980 and to 21 percent in 1989—has led to a rise in the quantity and quality of services consumers have purchased over the past decade, perhaps obscuring some of the effects of policies aimed at reducing the rate of increase in health spending over that period.

Finally, the medical malpractice environment has been cited as contributing to rising health costs. Although only about $5 billion—or 0.9 percent of all spending for health—was spent on medical malpractice premiums by all types of medical providers in 1988, the malpractice climate may also affect patterns of practice in ways that indirectly raise costs. For example, physicians may increase testing beyond the medically necessary level in the face of potential liability lawsuits and in the absence of agreed-upon practice guidelines.

Performance of the Health Sector

The characteristics of the markets for health insurance and health services combine to create a number of outcomes in the health care sector that are perceived to be problems. Three major problems are:

- The proportion of people without health insurance coverage has been growing over time—from 12.2 percent in 1978 to 15.7 percent in 1989—and the proportion of workers with insurance has been falling.
- Administrative costs associated with health care spending account for a high proportion of the costs of health care in the United States because of our multiple payer system, which requires tracking eligibility, marketing, risk assessment, monitoring of individual patient encounters, and a unique set of prices for each payer. In 1987, insurers' administrative costs were $23.9 billion, or 4.9 percent of spending in the United States, compared with 2.5 percent in Canada and 2.6 percent in the United Kingdom.
- Despite the exceptionally high level of spending for health care in the United States, health outcomes such as infant mortality rates and life expectancy at birth are no better here than in other industrialized countries.

Although the United States spends more than other industrialized countries, some specific aspects of our system that contribute to these higher per capita costs are perceived by many people to be desirable. For example, we value speed and accuracy of diagnosis and a short length of time between diagnosis and treatment. We also devote significant resources to basic medical research that yields improvements in diagnosis and treatment. Moreover, the current financing system permits rapid dissemination of new technologies, extending the benefits of research to the insured population with minimal waiting times.

POLICIES TO CONTROL HEALTH CARE COSTS

In response to concerns about rising health care spending and prices, many strategies for controlling health care costs have been developed and carried out during the past two decades, especially during the 1980s. Despite these efforts, spending on health has continued to rise at a dramatic rate. The variety of approaches adopted reflects the fact that controlling costs is a complex problem and that, in the United States, the market for health services is a diverse and uncoordinated system.

Cost Sharing

Although cost sharing by consumers has often been discussed as a potentially effective strategy for controlling health care costs, out-of-pocket spending for health care declined from 23 percent of total costs in 1980 to 21 percent in 1989. Even so, the United States remains significantly different from most other countries. For example, out-of-pocket costs are 7 percent in West Germany and 3 percent in the United Kingdom.

Evidence from studies of the effect of cost sharing on spending for health services does, however, suggest that if the average coinsurance rate in 1989 had been increased from 21 percent to 31 percent, a decrease in spending of between 1 percent and 2 percent would have occurred—or about $6 billion to $12 billion in 1989. This reduction in spending would probably result from fewer initial visits to ambulatory providers and would have more impact on the poor than on other consumers.

Managed Care/Controls on Use

Because there is evidence that many of the health services provided to consumers are unnecessary or inappropriate, managed care has been widely advocated in the United States since the early 1970s as a strategy for controlling costs. Managed care includes third-party payers' review and intervention in decisions about health services to be provided, and limitations on patients' choices of providers. Studies of its effectiveness suggest that managed care has a potential to reduce health care spending—although its effectiveness varies depending on the strength of the controls employed. The impact on health care spending is achieved through a one-time reduc-

tion in levels of use; managed care does not appear to affect the rate of increase in spending over time.

Effective managed care for one group of patients, however, does not necessarily slow the growth in total expenditures for all patients. Our fragmented system of financing makes it possible for providers to expand services and raise prices for other patients not getting managed care. The substantial administrative costs of managed care also offset some of the savings from using fewer services.

In contrast to the approaches to controlling use of services employed in the United States, several other industrialized countries monitor and review providers, rather than individual patients and procedures. This process is applied uniformly and comprehensively to all physicians, to identify those whose service patterns deviate from their peers. When indicators such as referral patterns, numbers of procedures and tests performed, and numbers of repeat visits deviate from the norm, committees monitoring regional health systems then review these physicians and, if warranted, penalize them.

Price Controls

Price controls on medical care have been imposed several times in the United States. Overall, the evidence from the Medicare experience of the potential effect of price controls on health care costs suggests that more services are provided when prices are reduced across the board; price controls on one type of service create incentives for providers to substitute other services for the controlled one; price controls established for a specific population group (such as Medicaid enrollees) may result in higher prices charged to other population groups; and, when prices are controlled for only some groups, they may have a less access to care. Thus, unless price controls are combined with systematic monitoring and review of all providers to prevent the volume of services from rising, their potential to solve the problem of health care costs is limited.

Competition

Competition among insurers and providers has increased over the past decade. The number of insuring organizations has grown, and many employees are offered a choice among several insurance packages sometimes with financial incentives to choose lower-cost, more efficient plans. The number of physicians relative to the population has grown, and physicians are now less able to control competition from other providers who perform services that overlap with those of physicians—and who generally charge lower prices than physicians for these services. Advertising by physicians, hospitals, dentists, and other providers—which was prohibited by medical ethics and state regulations in the past—has now become an accepted practice.

If competition were an effective strategy for controlling costs, health care costs—particularly in areas that have become much more competitive—should have risen more slowly over the past decade than they have. This outcome would not necessarily occur, however, if nonprice competition was the predominant response to changes in this market. Some research suggests that greater competition has led to product differentiation and higher costs in the health care market, rather than to lower prices and greater efficiency. The competition strategy, however, has not been fully put into place. Moreover, approaches to cost containment that rely on changing the conduct of markets may require substantial passage of time before the full effects are evident.

Regulation of the Market for Health Services

Because past efforts to control costs have had limited effect, some people have concluded that greater regulation of the market for health services is necessary. Regulatory strategies attempted in the United States include the Federal health planning and certificate-of-need programs and the state all-payer rate-setting programs for hospitals. In addition, strategies used in other countries—global budgeting and expenditure targets—might be effective here.

Health Planning and Certificate-of-Need Programs. The Health Planning and Resource Development Act of 1974 required that all states receiving Federal health resources enact certificate-of-need (CON) laws—providing for state review and approval of planned capital investments of health care institutions. By 1980, all states except Louisiana had enacted CON laws. Subsequent research on their effectiveness consistently found that they did not restrain hospital spending and, in 1986, CON requirements for states to receive Federal funds were dropped. Those who support health planning and CON requirements suggest, however, that CON in most states was applied in an erratic and politically motivated way that was not consistent with cost-consciousness and the orderly adoption of new technologies.

The governments of some other countries control the capital acquisitions of hospitals. In Canada and the former West Germany, for example, hospitals apply to the regional government for capital expenditures and the regional government provides funding only for approved investments. In Great Britain, the central government determines the national budget for capital costs, and decisions about capital acquisition are made at varying geographic levels depending on the type of expenditure. These restrictions on capital acquisition, which keep costs down but also tend to limit access to new technologies and treatments, appear to have led to a lower rate of technological diffusion than in the United States.

State All-payer Rate-setting Programs. During the past two decades, four states put in place statewide all-payer hospital rate regulation programs. Under these programs, the state establishes the reimbursement methodology under which hospitals in the state receive uniform payments for specific services from all third-party and direct payers. Results of nearly all of the studies of these systems find that they initially lowered costs by from 2 percent to 13 percent, and that they cut the rate of growth in hospital spending substantially below what would be expected in the absence of an all-payer system.

Controls on Expenditure Levels. Another regulatory mechanism for controlling health care costs is to set limits on spending prospectively. This can be done through global budgeting, under which the government sets the operating budget in advance for specific providers—most commonly hospitals. Or it can be done through caps on expenditures, under which the government sets either a fixed budget that absolutely controls spending levels or a target that triggers penalties if it is exceeded. While other countries have relied extensively on expenditure targets to influence physician spending, the Medicare volume performance standards for physicians put into effect in 1990 is the first such attempt in the United States. Some other industrialized countries combine expenditure targets for physicians' services with ongoing monitoring of the practice patterns of individual physicians, in order to reduce the potential for some physicians to increase their incomes at the expense of others.

If they are strictly applied, global budgeting and expenditure caps for overall spending or for types of services can limit the level and rate of growth of health care spending. Depending on how tightly they are set, however, they could adversely affect quality or access to care.

THE POTENTIAL TO CONTROL RISING HEALTH CARE COSTS IN THE UNITED STATES

Control of health care costs—through either a one-time drop in spending or a lower rate of increase—is much more difficult to achieve in the United States than in countries that have chosen to develop a coordinated national health care policy or a national health system. In the United States, attempts to control health spending in one segment of the market or for specific groups of consumers may sometimes be successful for the part of the market affected. The impact on overall health spending in the nation may be much less, however, since providers may compensate for lower revenues from one segment of the market by increasing prices for, or the quantity of services provided to, other groups.

During the 1980s, a number of strategies to control health care costs were carried out. Although it is difficult to quantify the overall effect of each change separately, there appears to have been little impact on the growth in total health spending. The average annual rate of increase in real health spending per person was 4.3 percent between 1980 and 1985 and 4.6 percent between 1985 and 1989. In addition, the share of GDP devoted to health spending rose from 9.2 percent in 1980 to 11.7 percent in 1989.

Evidence from other countries, and from research, suggests that it may be possible to achieve greater control over health care spending in the United States than has been apparent over the past decade. It would be necessary, however, to make changes in the financing and delivery of health care. Several policies, used in combination, could substantially increase our ability to control health care spending. These policies include: elimination of first-dollar coverage under insurance policies; uniform utilization monitoring and review applied to all physicians rather than to individual patients and specific procedures; uniform payment levels that encompass all payers (including a prohibition against billing patients for any additional amounts); health planning that establishes capital and technology targets relative to population at national and regional levels, and that does not reimburse for services provided through unapproved purchases; and effective national and regional budgets for overall spending or expenditure targets for specific types of spending.

Without significant changes, the United States is unlikely to achieve much greater control over health care spending than it has in the 1980s. Moreover, the conse-

quences of failure to obtain the benefits of effective cost containment will be many, including making it more difficult to address the other major failure of our health care system—the large and growing number of people in the United States without health insurance coverage.

To change the present system, however, we would have to make some concessions. Greater control over health care spending would probably mean less spending on research and development, longer waiting times for use of new technologies, and limitations on our existing choices of providers, health care coverage, and alternatives for treatment. Whether these trade-offs are desirable depends on the priority the nation places on controlling costs as against maintaining other characteristics of the current health care system.

[The full text of the Congressional Budget Office report, "Rising Health Care Costs: Causes, Implications, and Strategies," April 1991, has been retained in the Committee files.]

Prepared Statement of Dallas L. Salisbury

I am pleased to appear before you today to discuss health care costs and lack of access. My name is Dallas Salisbury. I am the president of the Employee Benefit Research Institute (EBRI), a nonprofit, nonpartisan, public policy research organization based in Washington, DC. EBRI has long been committed to the accurate statistical analysis of public policy benefits issues. Through our research, we strive to contribute to the formulation of effective and responsible health, welfare, and retirement policies. In keeping with EBRI's mission of providing objective and impartial analysis, our work does not contain recommendations.

◆ Introduction

The American public values the financial protection provided by health insurance. The health care delivery system in the United States has performed a number of miracles that were not possible 30, or even 10, years ago. People are surviving heart attacks and cancers that once were fatal; vital organs are being transplanted into individuals who then lead normal lives; premature babies are growing up healthy; diseases have been eradicated. At the same time, national health expenditures have been increasing at twice the rate of general price inflation for over a decade. Thirty-four million Americans lack health insurance, which limits their ability to pay for health care services.

The rapid increase in health care costs has challenged the health care delivery system and increased the costs of private and public health insurance coverage to the consumer. The results have been a reduction in health insurance coverage and introduction of cost management techniques that have reduced the providers' ability to subsidize uncompensated care.

◆ Public Attitudes on Health Care

The public will be the arbiter of whether or not health reform initiatives are focused properly. To assess the shifting tides of public opinion, EBRI and The Gallup Organization, Inc. have conducted a monthly series of national public opinion polls on public attitudes toward economic security issues such as health insurance, health care satisfaction, and the value of benefits since June 1989. As elected officials well know, the tide of opinion can shift rapidly and a move from "what do you want?" to "what are you willing to pay?" can produce very different results.

Our surveys indicate that obtaining health insurance is a top priority for most Americans. A 1990 EBRI/Gallup poll found that 61 percent of working Americans regard health insurance as their most important employee benefit; 59 percent said they would not accept a job that did not provide health benefits. Respondents said that their employer would have to pay them an average of $4,219 in additional income to forgo their current employer-provided health benefits. Individuals prefer the hidden costs of lower wages over direct payments like premium co-payments.

Not only do Americans value the provision of insurance, the majority are satisfied with the health care they receive. However, they are not satisfied with the U.S. health care system as a whole. A 1991 EBRI/Gallup poll found that while more than half of Americans (56 percent) rate the U.S. health system as fair or poor, most of those who stated they have family physicians rate the quality of care they receive as excellent or good (92 percent). In addition, among respondents who had been hospitalized during the last year (26 percent of all respondents), a large majority (82 percent) rate the care they received as excellent or good.

When asked what they liked most about the overall quality of the care they received from their physicians, respondents cited factors that are synonymous with higher cost such as attention and care (12 percent), friendliness (11 percent), and availability (10 percent). When asked what they liked least about their care, no single factor received special emphasis, but they were factors that generally reduce cost including waiting time (8 percent), insufficient time spent by physician with patient (6 percent), and limited availability (4 percent). In addition to giving high ratings to their personal health care, respondents also expressed satisfaction with their health insurance benefits.

These findings suggest that the satisfaction that insured Americans feel for their health care may reduce their willingness to accept reform proposals that may alter or ration the care they receive.

A 1990 EBRI/Gallup survey explored public attitudes toward policy options for health care reform. These surveys indicate a preference for employment based insurance versus government provision. Fifty-four percent of respondents said the federal government should provide health coverage for all Americans. Twenty-seven percent continued to support government-provided health insurance even if it meant higher taxes, but would be willing to pay only an additional $337.10 in taxes per year, on average. More than one-half of respondents (56 percent) said that employers should be required to provide health benefits at no cost to employees. More than four respondents in five (84 percent) said employers should be required to provide coverage if employees paid part of the cost; these respondents said they would be willing to pay an average of $59.50 per month (or $714 per year).

◆ Health Care Costs[1]

U.S. expenditures on health care exceeded 12 percent of Gross National Product (GNP) in 1990—more than twice the proportion of GNP than in 1960 and more than that in any other industrialized country. In the last 25 years, the U.S. health care sector has outgrown other sectors in the economy by an average of 3 percent annually. The aging population and advances in medical technology mean that this trend is likely to continue. Current discussions of health care expenditures focus on perceived problems in the system, such as quality and access to health care, but they also encompass the notion that the United States is spending "too much" on health care—that health care consumption and expenditures are inherently too high. These perceptions have led employers and government policymakers (who together account for 63 percent of total U.S. expenditures on health services and supplies) to make assorted proposals for reforming the financing and delivery of health care.

Why are Health Care Expenditures Growing?

Between 1947 and 1987, the U.S. health care sector outgrew the combined other sectors of the economy by an average of 2.5 percent annually. Health care prices rose 1.6 percent faster annually than non-health care prices, and the quantity of health care delivered grew 0.9 percent faster than other quantities. More recently, from 1977 to 1987, the health care sector outgrew other sectors of the economy by an annual average of 3.0 percent, with medical services prices outgrowing prices in non-health industries by an average of 3.0 percent, and the quantity of medical services delivered averaging the same growth as quantities of other goods and services delivered. The relatively rapid growth of prices may be explained by factors such as the growth in the price of medical labor and capital and the slower growth in medical productivity than in non-health sectors of the economy. Reasons for the relatively rapid growth in the quantity of health care services delivered between 1957 and 1977 (1.2 percent between 1957 and 1967 and 2.4 percent between 1967 and 1977) include the development and utilization of new technologies and the spread of health insurance. Ongoing increases in health services wages and the aging baby boom generation may cause the price and quantity of health care services, respectively, to continue to outgrow those of other goods and services.

As the baby boom generation ages, the elderly population will grow from 31.7 million people in 1990 (13 percent of the population) to 70.1 million people (23 percent of the population in 2060), and the demand for health care services will increase. The elderly population accounts for a disproportionately high share of health care expenditures because the incidence of sickness increases with age. In 1989, for example, elderly individuals (age 65 and over) averaged 9.1 annual physician contacts, almost twice as many as individuals between the ages of 25 and 44. Likewise, patients age 75 and older averaged 4,098 days of hospital care per 1,000 persons per year, more than seven times as many days as patients between the ages of 35 and 44. Table one demonstrates the age rated individual and family premiums for group health coverage for an employer whose firm size is 28 in Washington, D.C. between 1987 and 1991. It clearly shows the implications of population aging.

Table 1
Age Related Health Premiums for a Washington, D.C. Employer with 28 Employees, 1987-1991

Age and Type of Coverage	Total Premium Cost (Employer and Employee)				
	March 1987	March1988	March 1989	March 1990	March 1991
Single Coverage					
Less than 29	$71.36	$89.90	$140.16	$148.44	$159.74
Aged 30-34	$89.20	$112.40	$175.20	$185.54	$199.68
Aged 35-39	$107.04	$132.40	$210.26	$222.64	$239.60
Aged 40-44	$130.82	$164.82	$256.96	$272.12	$292.86
Aged 45-49	$154.60	$194.80	$303.70	$321.60	$346.10
Aged 50-54	$166.50	$209.78	$327.04	$346.34	$372.70
Aged 55-59	$166.50	$209.78	$327.04	$346.34	$372.70
Over Age 60	$166.50	$209.78	$327.04	$346.34	$372.70
Family Coverage					
Less than 29	$177.16	na	$324.66	$343.60	$369.82
Aged 30-34	$212.58	$251.72	$389.58	$412.30	$443.78
Aged 35-39	$248.00	$293.68	$454.52	$481.04	$517.72
Aged 40-44	$336.58	na	$616.84	$652.82	$702.62
Aged 45-49	$425.16	na	$779.16	$824.62	$887.52
Aged 50-54	$478.32	na	$876.56	$927.70	$998.48
Aged 55-59	$499.56	na	$945.52	$968.94	$1,042.84
Over Age 60	$499.56	na	$915.52	$968.94	$1,042.84

In addition to increasing the quantity of health care services provided, the increasing ratio of elderly to working individuals will contribute to an increase in the proportion of GNP that is accounted for by health expenditures. Medicare expenditures alone, which are estimated to have represented 1.9 percent of GNP in 1990, are projected to increase to 3.0 percent of GNP in the year 2000 and 6.8 percent of GNP in 2060. These figures suggest that health care financing for the elderly will continue to be a difficult issue for both public policymakers and private employers. Given the magnitude of such projections, it is not surprising that many employers with relatively large retiree populations have been at the forefront of proposals to reform the U.S. health care delivery system.

Why are We Concerned About the Growing Health Care Sector?

In many cases, when observers discuss a sector of the economy that is flourishing, it is considered to be a favorable situation. After all, growing businesses often create desirable by-products such as jobs, revenues (both of which generate tax revenues), capital investment, investment in research and development, and foreign exports. Health care delivery industries supplied 16 percent of net new jobs between 1980 and 1990. Further, industries such as pharmaceuticals and medical equipment have higher than average levels of investment on research and development in addition to a positive balance of trade. Given these facts, why are so many parties upset over the current boom of the health care sector?

Concerns over the current level and growth of health spending may be driven in part by employers' perception that health care expenditures represent an increasingly large component of employee compensation (5.8 percent in 1989 compared with 1.5 percent in 1965), federal and state governments' perception that Medicare and Medicaid represent a growing proportion of public budgets (29.5 percent in 1989 compared with 11 percent in 1965), and individuals' perception that a greater proportion of their disposable income is going toward the purchase of health insurance and health care services (5.1 percent in 1989 compared with 4.2 percent in 1965). Indeed, health expenditures do represent a growing proportion of compensation, disposable income, and public budgets.

Employers. The employer share of total health expenditures has remained between 28 and 30 percent since 1980. Nonetheless, health care expenditures are the fastest-rising component of employee compensation. Because employers' health care expenditures represent a growing cost of production, many argue that such spending puts them at a competitive disadvantage and is hampering their individual competitiveness and U.S. competitiveness overall. These observers are apt to measure employer health care expenditures as a percentage of corporate profits or to divide such expenditures by unit output thereby yielding the amount of health care in the price of a unit product (a car, for example). Health care costs, however, are only one component of total compensation, the measurement that is generally used to determine productivity and competitiveness. Table 2 illustrates that employer spending for total compensation as a proportion of corporate after-tax profits has actually *declined* since 1985 and that employer spending on wages and salaries is a much more significant determinant of total labor expenditures than is employer spending on health care.

Table 2
Employer Spending on Health Insurance,[a] Wages and Salaries, and Total Compensation[b] in Billions of Dollars and as a Percentage of Corporate After Tax Profits, Selected Years

	Employer Spending on Health Insurance[a]		Employer Spending on Wages and Salaries		Employer Spending on Total Compensation[b]	
Year	$billions	Percentage of Corporate After-Tax Profits	$billions	Percentage of Corporate After-Tax Profits	$billions	Percentage of Corporate After-Tax Profits
1950	$0.7	3%	$147.2	589%	$155.4	622%
1960	3.4	13	272.8	1003	296.7	1091
1970	14.6	35	551.5	1323	618.3	1483
1980	71.6	48	1372.0	916	1638.2	1094
1985	124.3	97	1975.2	1546	2367.5	1853
1989	178.1	103	2573.2	1491	3079.0	1784

Source: EBRI tabulations of data from the U.S. Department of Commerce, National Income and Product Accounts.
[a]Includes employer contributions for group health insurance, Medicare Hospital Insurance, and military medical insurance.
[b]Includes wages and salaries, health benefits, and all other non-cash benefits.

The notion that benefits are only one element of a total compensation package that an employee and employer negotiate is not new. Outside of collectively bargained contracts, however, some employers claim that they do not (and could not) make *explicit* trade-offs between benefits and cash compensation.

Many economists, however, argue that such trade-offs *are* made in the long run—whether implicitly or explicitly—and that it is therefore employees—not employers—who bear the burden of increasing health care costs in the form of lower non-health compensation. If that argument is true, it is unlikely that increasing business spending on health care costs per se is eroding global competitiveness. Rather, it is employees who are experiencing a decline in the income they otherwise might have had available for non-health consumption. Regardless of who bears the burden of increasing health care expenditures, in the aggregate, employer spending on health care represents less than 6 percent of total labor costs. Therefore, changes in employer health expenditures have less impact on the growth rate of total compensation than do changes in employer expenditures on wages and salaries (which represent 84 percent of wages and salaries) (table 3).[2] Moreover, since labor productivity generally measures output in terms of *total* labor costs, total compensation seems to be a more relevant measure for issues of competitiveness and profitability.

Table 3
Annual Growth Rates:
Employer Spending on Total Compensation, Wages and Salaries, and Health Insurance, 1960-1989

Year	Health Insurance	Wages and Salaries	Total Compensation
1961	9.7%	2.8%	3.0%
1962	13.5	6.7	7.1
1963	9.5	5.2	5.5
1964	13.0	7.3	7.4
1965	13.5	7.7	7.8
1966	25.4	10.1	10.8
1967	14.9	7.1	7.3
1968	24.7	10.0	10.3
1969	16.0	9.8	10.2
1970	18.7	6.4	6.9
1971	11.7	6.0	6.7
1972	17.2	9.3	10.1
1973	25.1	10.9	11.9
1974	12.1	9.0	9.7
1975	17.2	5.5	6.4
1976	22.6	10.4	11.5
1977	19.5	10.5	11.2
1978	15.2	12.6	13.0
1979	17.2	11.8	12.2
1980	15.2	9.6	9.8
1981	18.9	10.1	10.3
1982	14.7	5.0	5.5
1983	11.0	5.7	6.0
1984	9.0	9.7	9.6
1985	5.2	7.4	6.9
1986	9.3	6.1	6.1
1987	9.6	7.4	7.1
1988	10.0	8.0	8.1
1989	8.8	5.9	5.9

Source: EBRI tabulations of U.S. Department of Commerce data, 1990.

Governments. Health care spending has grown as a proportion of revenues at both the federal level and the state and local government level. Federal government health care spending represented 15.1 percent of federal revenues in 1989, more than 4 times as much as in 1965, before the implementation of Medicare and Medicaid. As a proportion of total U.S. health expenditures, the change is not nearly as significant. Federal government expenditures on health care accounted for 9 percent of total expenditures on health services and supplies in 1965, 15 percent in 1967 (after the implementation of Medicare and Medicaid), and 16 percent in 1989. State and local health spending represented 14.4 percent of state and local revenues in 1989, nearly twice as much as a proportion of revenues as in 1965. In terms of total U.S. spending on health services and supplies, however, state and local spending has changed little, representing 12 percent of total U.S. expenditures in 1965 and 14 percent in 1989.

While the proportion of the total health care bill paid by governments has remained essentially constant since the implementation of Medicare and Medicaid, the share of public budgets consumed by health care continues to grow because public budgets have remained relatively fixed as a proportion of GNP while health care expenditures have increased. The increase in the proportion of public budgets consumed by health care expenses suggests that increases in public health spending are now coming at the expense of other public expenditures such as infrastructure and education (human capital). This may represent a more likely threat to American competitiveness than employer contributions to health expenditures.

Individuals. Despite the fact that more employers today require premium contributions for group plans than they did 10 years ago, and deductibles are higher and copayments more common, individual health spending as a share of adjusted personal income has increased by only 0.9 percentage points since 1965. Moreover, individual households pay a considerably smaller proportion of total U.S. health spending than they did in

1965, and virtually the same proportion as they have since 1980. However, if one accepts the premise that employer increases are passed on to employees in the form of lower wages and salaries, individuals may be bearing more of the burden of growing health care expenditures.

What initiatives have employers and insurers undertaken to reduce health care expenditures?
Employers and insurers continue to implement various measures in an effort to manage health care costs. Cost containment initiatives include cost sharing through copayments, deductibles, and premium sharing; alternative delivery systems such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs); utilization review techniques; expanded coverages for services or settings believed to be more cost effective; and health promotion programs. Cost management programs may be voluntary or there may be a financial incentive for participation. While some employers have reported success with specific initiatives, others remain dissatisfied, and most continue to search for ways to control their increasing costs.

Employer efforts to control their health care expenditures through mandatory contributions to monthly premiums, copayments, increased deductibles, and the implementation of choicemaking benefit plans may have begun to sensitize patients to the magnitude of health care costs. In 1989, 48 percent of employees in medium- and large-sized establishments with group health coverage were in plans that required a contribution to premium for individual coverage ($25 per month, on average), up from 26 percent in 1980 ($9 per month, on average). However, even if patients are aware of the costs of health care, they can lack much of the information necessary to evaluate and make rational purchase decisions about health care treatment. Most purchase decisions, in fact, are made by the providers of health care, who themselves are largely unable to make fully informed decisions because medicine is an imprecise science. Therefore it is not certain whether cost sharing can effectively control the quantity of health care services delivered.

HMOs give providers financial incentives to provide cost effective care and are therefore generally identified with cost containment. A survey by A. Foster Higgins found that annual HMO premiums were lower, on average, than fee-for-service premiums in 1989 ($2,319 versus $2,600, respectively). These figures represent a 16.5 percent increase from 1988 for HMOs, compared with 20.4 percent growth for fee-for-service plans. However, many employers feel that HMOs have been unsuccessful in reducing costs. Their reasons include a 17 percent annual increase in premiums, coupled with the increased costs associated with offering HMO options, including the added administrative costs of multiple plans and possible increases in indemnity rates associated with adverse selection.[3] Employers are cutting back on the number of HMO options they offer and negotiating harder for rate cuts by pressing for increased experience rating (group rates based on actual historical claims experience from the group itself). According to the U.S. Department of Labor, HMO enrollment among employees with employer-sponsored health plans grew steadily from 2 percent in 1980 to 17 percent in 1989.

PPOs are a relatively new type of health care delivery network in which an organization, generally an insurer, contracts with a network of doctors, hospitals, and other health care providers to provide services at a discounted price schedule. Providers enter these agreements hoping to generate a higher volume of business. PPOs may be offered on a stand-alone basis or as an option within a traditional indemnity plan. In the latter case, insurers usually encourage participants to use the preferred providers by waiving deductibles or offering more attractive coinsurance provisions. PPOs appear to be gaining popularity: the U.S. Department of Labor found that in 1989, 10 percent of participants in medium-sized and large employer health plans were enrolled in PPOs, compared with only 1 percent in 1986. Employers are divided in their responses to PPO effectiveness at controlling costs. A. Foster Higgins & Co., Inc. found that 55 percent of employers surveyed said they were unable to measure the effect of PPOs on medical costs, while 24 percent said they reduced costs, 17 percent said there was no effect, and 4 percent said PPOs increased medical costs.

From the participant's perspective, the relative attractiveness of the various types of plans often depends on the value the individual assigns to freedom of choice in the selection of providers. Since Americans have long been accustomed to fee-for-service medicine, many place a high value on freedom of choice. For this reason, some insurers have found that plans that preserve the ultimate right to choose while giving powerful incentives to use an identifiable group of providers are more successful in the market. These plans allow the employee

to choose a fee-for-service delivery mode or an HMO or PPO option within a single plan at the point of service. In these plans, participants incur fewer out-of-pocket expenses when using designated HMO or PPO providers than when they choose fee-for-service delivery. Allied-Signal and Southwestern Bell are notable among companies that have implemented such plans. AT&T plans to implement a point-of-service managed care network that will have the nation's largest enrollment and will be unique in that the company's unions have agreed to help write the standards and select the bidders. While they are a relatively new phenomenon, point-of-service plans are gaining in popularity. Interstudy found that enrollment in open-ended HMOs, which allow enrollees to opt for care from nonnetwork providers, rose 118 percent (from 476, 788 enrollees to 1,041,214 enrollees) from July 1988 to July 1990, compared with 7 percent growth in "pure" HMO enrollment over the same period.

In addition to offering plans with cost management features, some employers have begun to sponsor corporate programs that may help to manage health care costs (and possibly boost productivity) by promoting wellness. Such programs include smoking cessation, weight control, fitness, stress management, hypertension, health risk appraisal, and back care. While programs to promote wellness are generally voluntary, several companies—U-Haul International and Baker Hughes, Inc., among them—have established programs that require employees who smoke or who are significantly overweight or underweight to pay more than other employees toward the cost of health insurance.

◆ Access to Health Insurance[4]

Private health insurance and publicly financed health programs cover most Americans under age 65 and virtually all of those above age 65, providing access to preventive medical services. Most private health insurance coverage is employment based. Health insurance coverage has increased consumer demand for health care services and stimulated the development of new procedures and techniques. The increased cost of health care services has further increased consumer demand for health insurance.

Access to health insurance and access to health care services are different. Individuals without health insurance are able to access health services, but may face financial or other barriers that make access to health services more difficult than it is for those with insurance. Uninsured individuals face limited access to basic health care services in part because they lack private health insurance and are ineligible for (or otherwise not receiving) publicly financed health care. Uninsured individuals may be forced to seek care for preventable ailments that could have been treated less expensively with access to preventive health services. The cost of inefficient, uncompensated care is borne by all payers in the health care delivery system.

Eighty-four percent of Americans Have Health Insurance

In 1978, approximately 88 percent of the nonelderly population was covered by either private health insurance or a publicly financed health program. However, both the number and the percentage of the nonelderly population covered by health insurance have declined over the past 10 years. In 1989, 84 percent of the nonelderly population was covered, leaving more than 16 percent, or 34.4 million people, without health insurance coverage.

The majority of the nonelderly population receives health insurance coverage from private, employer-sponsored group health plans. Nearly 66 percent of the nonelderly were covered either through their own current or former employer or as a dependent of someone with employer coverage (table 4). Others were covered by individually purchased private health insurance (9 percent) and publicly financed health programs (12 percent).[5]

Most of the Uninsured Are Working Adults

In 1989, most of the uninsured were working adults (54.6 percent) while the remainder were nonworking adults (16.7 percent) or children (28.7 percent). More than 85 percent of the uninsured were either workers or dependents of workers. Even though only 12 percent of full-year full-time workers and their dependents were uninsured in 1989, they represented 54 percent of the uninsured because the majority of the workers are employed consistently on a full-time basis. Nonworkers were more likely to be uninsured than all other working groups—nearly 21 percent did not have any health insurance in 1989.

Table 4
Nonelderly Population with Selected Sources of Health Insurance by Work Status and Income Characteristics
EBRI Analysis of the March 1990 CPS

	Total	Total Private	Employer Coverage			Total Public	Medicaid	No Health Insurance Coverage
			Total	Direct	Indirect			
	(millions)							
Total	213.7	160.4	140.8	71.2	69.6	26.2	18.5	34.4
Own Work Status								
Family head worker[a]	74.9	60.9	54.6	51.2	3.4	4.3	2.1	11.6
Other workers	48.1	39.8	35.0	17.7	17.3	2.3	0.9	7.2
Nonworkers	27.5	15.2	11.7	2.2	9.5	8.4	5.4	5.7
Children	63.2	44.4	39.4	0.1	39.4	11.2	10.1	9.9
Family Head[a] Work Status								
Full-year,								
never unemployed	165.4	139.6	125.9	62.8	63.1	9.1	4.5	21.5
full-time	155.7	133.7	121.9	60.6	61.3	7.7	3.6	18.7
part-time	9.7	6.0	4.0	2.2	1.8	1.4	0.9	2.8
Full-year,								
some unemployment	15.6	8.8	7.5	3.8	3.6	2.6	2.1	4.8
Part-year	10.3	5.1	3.4	1.8	1.5	2.7	2.2	3.1
Nonworker	22.4	6.9	4.1	2.7	1.4	11.8	9.7	5.0
Income Level								
0-99% of poverty	28.3	6.3	3.5	1.5	2.1	13.1	12.4	9.8
100-124% of poverty	8.6	3.8	2.8	1.2	1.6	1.9	1.6	3.3
125-149% of poverty	8.7	4.9	3.7	1.5	2.3	1.5	1.1	2.8
150-199% of poverty	18.7	12.5	10.4	4.4	6.1	2.1	1.3	4.8
200-399% of poverty	74.0	62.8	56.2	25.8	30.3	4.4	1.7	9.2
400% or more of poverty	75.4	70.1	64.1	36.9	27.2	3.1	0.6	4.4
	(percentage within work status and income categories)							
Total[b]	100.0%	75.0%	65.9%	33.3%	32.6%	12.2%	8.7%	16.1%
Own Work Status								
Family head worker[a]	100.0	81.3	72.9	68.3	4.6	5.8	2.9	15.1
Other workers	100.0	82.8	72.8	36.8	36.0	4.7	1.9	15.0
Nonworkers	100.0	55.3	42.7	8.2	34.5	30.4	19.8	20.8
Children	100.0	70.3	62.4	0.1	62.3	17.7	15.9	15.6
Family Head[a] Work Status								
Full-year,								
never unemployed	100.0	84.4	76.1	38.0	38.1	5.5	2.7	13.0
Full-time	100.0	85.8	78.3	38.9	39.4	5.0	2.3	12.0
Part-time	100.0	61.3	40.7	22.4	18.3	13.9	9.4	28.6
Full-year,								
some unemployment	100.0	56.3	48.1	24.7	23.4	16.6	13.5	31.1
Part-year	100.0	49.3	32.4	17.7	14.7	26.4	21.4	29.7
Nonworker	100.0	30.8	18.2	12.2	6.1	52.6	43.5	22.2
Income Level								
0-99% of poverty	100.0	22.4	12.5	5.2	7.3	46.5	43.8	34.8
100-124% of poverty	100.0	43.7	32.2	13.3	18.8	22.4	18.5	38.3
125-149% of poverty	100.0	55.5	42.4	16.6	25.8	16.7	12.4	32.2
150-199% of poverty	100.0	67.2	55.8	23.4	32.4	11.2	6.9	25.7
200-399% of poverty	100.0	84.8	75.9	34.9	41.0	6.0	2.2	12.5
400% or more of poverty	100.0	93.0	85.1	49.0	36.1	4.1	0.7	5.8

[a] Family head refers to the family member with the highest reported earnings in 1989. In families of nonworkers, the family head is the family member with the highest reported personal income.
[b] Totals do no add to 100 percent because individuals may have coverage from more than one source.

The majority of uninsured workers reported their industry of primary employment as retail trade, services, or manufacturing. Workers were most likely to be uninsured if they were self-employed or working in agriculture, construction, retail sales, or services.

Health Insurance Coverage Is a Function of Employer Size

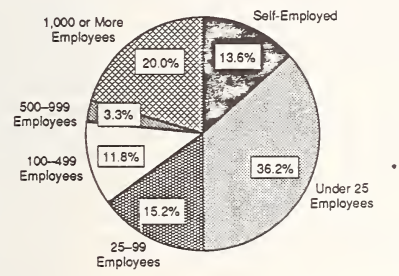
The rising cost of health insurance premiums and the practice of medical underwriting have made it expensive for small employers to offer health insurance to their employees. There are several reasons that small firms face higher costs. First, insurance companies usually charge higher premiums for group health coverage in a small firm because the risk is spread over fewer participants and frequently base premiums on age. In addition, because small firms often have higher turnover rates and seasonal unemployment, they face higher administrative costs when trying to provide coverage for these workers. Finally, because the fixed costs of offering health benefits are similar for firms of all sizes and small employers are unable to spread these costs over a large number of employees, their per capita cost of providing health insurance is higher than that of larger firms.

In 1989, 26 percent of self-employed workers and 31 percent of workers in firms with fewer than 25 employees were covered through their own employers' health plan compared with nearly 72 percent of those working for firms with 1,000 or more employees. Self-employed workers and workers in firms with fewer than 25 employees made up 49.8 percent of all uninsured workers in 1989 (chart 1). An additional 15 percent of all uninsured workers were in firms with between 25 and 99 employees. After taking indirect employer sponsored coverage and public coverage into account, almost 28 percent of workers in firms with fewer than 25 employees were uninsured compared with only 8 percent of workers in firms with 1,000 or more employees. In 1989, although only 22 percent of the nonelderly population lived in families whose family head worked for a firm with less than 25 employees, this group accounted for nearly 40 percent of the uninsured.

Health Insurance coverage is related to income and earnings

Lower paid workers are less likely to be covered by employer sponsored health insurance than other workers and are, therefore, less likely to be covered by private health insurance. This may be related to the nature of the employment (part-time vs. full-time or part-year vs. full-year) or the industry (worker may be in a low paying industry or an industry less likely to offer health insurance). Thirty-six percent of wage and salary workers earning less than $10,000 annually were covered through their employer's plan compared with 90 percent of wage and salary workers earning more than $50,000 annually. Among all wage and salary workers, 28 percent of workers with earnings below $10,000 were uninsured compared with only 2.0 percent of workers with earnings above $40,000.

Chart 1
Workers without Health Insurance Aged 18–64, by Firm Size
EBRI Analysis of the March 1990 CPS



18.8 Million Uninsured Workers Aged 18–64

Families with very low income were much more likely than those with higher income to be covered by publicly financed health programs. More than 46 percent of people in families with income below the poverty line were covered by public health insurance coverage in 1989 compared with only 4 percent of those in families with income above 400 percent of the poverty line.

The uninsured are concentrated disproportionately in low-income families. In 1989, 60 percent of the uninsured were in families with income under 200 percent of the poverty level ($24,200 for a family of four in 1989). Generally, as income increases, the percentage of the population without health insurance decreases.

Nearly 35 percent of individuals in families with income under the poverty line were uninsured compared with about 6 percent of those in families with income above 400 percent of the poverty level.

◆ Conclusions

The majority of Americans consider health care to be a right. Although most prefer care with no cost, they are willing to share some costs explicitly and more costs on a hidden basis. Americans want "reform", but only reform that means more caring-providers, more accessibility, no risk of forfeiture, and lower costs.

Business, labor, and government also view health care as a right. Each is searching for a reform that will provide greater access at a lower cost. Yet, because they must find the money, they are in a tough position. Demographics and technology both play against those who want to spend less. The data in this testimony as well as other available data show that per capita health care costs rise dramatically with age. The average age of the population is increasing and there are growing numbers of people over age 65 and over age 85. Even if increased efficiency were able to reduce health care expenditures for each age group by 25 percent, health care spending would continue to increase as a result of changing demographics. Therefore, achieving health care reform that aims to reduce spending will be extremely difficult.

The government , labor leaders, and employers have been trying to make the health care system more cost effective as well as increase access and quality. Although their efforts may produce results, they cannot provide universal access to health services at a lower overall cost. The pursuit of greater access and better quality for better value can be successful, but not without paying for it.

◆ Footnotes

[1] The following section draws from *EBRI Issue Brief #114*, "Health Care: What Role in the U.S. Economy?" forthcoming. To order, please call (301) 338-6946.
[2] While this is true in the aggregate, individual employer experience may vary. Retiree health care costs and age of active workforce as well as size of firm all affect the outcome.
[3] Various studies indicate that when there is a choice between an HMO and a traditional indemnity plan, younger, healthier employees may be more likely to opt for the HMO, leaving a higher-risk group in the indemnity plan and thereby causing indemnity premiums to increase.
[4] These data are taken primarily from an EBRI Special Report entitled "Uninsured in the United States: The Nonelderly Population without Health Insurance" published in April 1990. To order, please call Debbie Moss at (202) 775-6315.
[5] Because individuals may be covered by more than one source, totals do not add to 100 percent.

PREPARED STATEMENT OF DON SUMMERS

My name is Don Summers. Thank you very much for the honor and privilege of speaking to you today. I have come to speak to you on behalf of my business, my family and the 500,000 other members of the National Federation of Independent Business regarding the health insurance crisis. The health care crisis influences the continuing operation of all small, family-owned businesses.

Our company, Austin Welder and Generator Service, in Austin, Texas, was started in 1978 by myself and my oldest son. In December of 1978, we were joined by my second son.

Our company specializes in the maintenance and repair of electric welding equipment and power generating systems such as emergency back up generators at hospitals and large office buildings.

We currently have nine full-time employees, including family members. We have no part-time employees.

When we started the company in 1978, our gross income was $16,500. In 1990, our gross income had increased to $610,000, and our payroll was approximately $210,000. Our year end net profit was 1.54% or approximately $9,400.

Since first opening our business, we have felt a very strong moral as well as business obligation to provide quality health insurance for our employees. We began providing that benefit in about 1980, offering health insurance for employees and their families. The cost of this insurance was paid entirely by my company.

Between 1980 and 1990, my business had four different health insurance plans. Under each one, costs became so prohibitive that I was forced to search for a less expensive plan that still provided good coverage.

In 1990 we had to make an extremely difficult decision. In May of that year, the cost of our health insurance had increased to the point that it exceeded our monthly profit after all other expenses had been paid. Despite the increases, our company continued to provide coverage but with a higher deductible. Even by increasing that deductible from $300 to $600, we still found the cost of the policy too prohibitive for our company and for our employees.

During that time, our accountant and I spent a great amount of time searching for more affordable coverage. Personally, I have trouble enough keeping up with the advances and changes in our own industry. None of us in our company has the time to become an expert on health insurance. So we must depend on the integrity of an agent or other insurance industry representative to help us make the right choice.

In addition to pursuing higher deductible plans, we looked at other standard plans and HMOs as possible ways to reduce the cost of health insurance to our company. However, our carrier had explained that for companies in our size group, costs were escalating.

Finally, frustrated and saddened, we had no choice but to cancel our coverage and announce to our employees that as of September 1, 1990, they would have no health insurance. That was, without doubt, the most painful announcement that I have ever had to make. To the best of my knowledge, none of our employees has since acquired health insurance on their own.

In a small business, a good health insurance plan not only reduces the strain and worry on the part of the employee. It also allows us, the employer, to hire better trained, more professional employees. It upsets me not to be able to afford to provide coverage to my employees.

I believe that state health care mandates are a major contributing factor to the increased cost of coverage. In Texas, *no basic health plan exists* that will allow an employer to purchase a basic health care package. By "basic health care," I mean a policy that might not cover minor illnesses like a cold or sore throat, or other non-life threatening illnesses, but one that would gain access to doctor or hospital care for the more serious illnesses.

A Federal mandate requiring small businesses to provide health insurance would, without any doubt, lead to the reduction in size or closure of many businesses. I am convinced that even if the rates for mandated plans were low at the onset, they would soon increase to the point of being too expensive because of medical cost inflation.

The small business is the heart and soul of America. Many of us, as owner/operators of small businesses, are in "face to face" contact with all of our employees every day, and are therefore intimately aware of family health problems. It deeply troubles me to hear of someone needing health care and not getting it because it is too expensive.

Please, gentlemen, help me, other business owners and our employees find basic health insurance packages that are affordable.

Before I close I would like to submit for the record five other statements by small businesses owners from around the country. I was struck by how similar our problems are—we are all caught in a conflict between our values and the prohibitive cost of health insurance.

Thank you very much for today's opportunity to tell you my story.

HEALTH INSURANCE PREMIUMS - 1987 - 1990 - AUSTIN WELDER & GENERATOR SERVICE, INC.

DATE	D. SUMMERS	K. E. S.	D. F. S.	F. T. H.	S. F. E.	C. S. S.	TOTAL
Jan/01/87	$170.88	$170.88	$170.88	$170.88	$170.88	$56.73	$911.13
Feb/01/87	$170.88	$170.88	$170.88	$170.88	$170.88	$56.73	$911.13
Mar/01/87	$170.88	$170.88	$170.88	$170.88	$170.88	$56.73	$911.13
Apr/01/87	$170.88	$170.88	$170.88	$170.88	$170.88	$56.73	$911.13
May/01/87	$199.08	$199.08	$199.08	$199.08	$199.08	$66.51	$1,061.91
Jun/01/87	$199.08	$199.08	$199.08	$199.08	$199.08	$66.51	$1,061.91
Aug/01/87	$199.08	$199.08	$199.08	$199.08	$199.08	$66.51	$1,061.91
Sep/01/87	$199.08	$199.08	$199.08	$199.08	$199.08	$66.51	$1,061.91
Dec/01/87	$262.80	$182.50	$185.90	$192.40	$182.50	$43.50	$1,049.70
Jan/01/88	$260.10	$182.10	$185.40	$191.70	$182.10	$43.10	$1,044.50
Feb/01/88	$260.10	$182.10	$185.40	$191.70	$182.10	$43.10	$1,044.50
Mar/01/88	$260.10	$182.10	$185.40	$191.70	$182.10	$43.10	$1,044.50
Apr/01/88	$283.50	$227.00	$216.50	$244.50	$216.50	$58.00	$1,246.00
May/01/88	$283.50	$227.00	$216.50	$244.50	$216.50	$58.00	$1,246.00
Jun/01/88	$283.50	$227.00	$216.50	$244.50	$216.50	$58.00	$1,246.00
Aug/01/88	$283.50	$227.00	$216.50	$244.50	$216.50	$58.00	$1,246.00
Sep/01/88	$283.50	$227.00	$216.50	$244.50	$216.50	$58.00	$1,246.00
Oct/01/88	$283.50	$227.00	$216.50	$244.50	$216.50	$58.00	$1,246.00
Nov/01/88	$374.50	$262.00	$250.50	$283.50	$250.50	$65.00	$1,486.00
Dec/01/88	$374.50	$262.00	$250.50	$283.50	$250.50	$65.00	$1,486.00
Jan/01/89	$374.50	$262.00	$250.50	$283.50	$250.50	$65.00	$1,486.00
Feb/01/89	$374.50	$262.00	$250.50	$283.50	$250.50	$65.00	$1,486.00
Mar/01/89	$374.50	$262.00	$250.50	$283.50	$250.50	$102.00	$1,523.00
Apr/01/89	$374.50	$262.00	$250.50	$283.50	$250.50	$102.00	$1,523.00
May/01/89	$566.50	$390.00	$370.50	$473.00	$370.50	$176.50	$2,347.00
Jun/01/89	$566.50	$390.00	$370.50	$473.00	$370.50	$176.50	$2,347.00
Jul/01/89	$566.50	$390.00	$370.50	$473.00	$370.50	$176.50	$2,347.00
Aug/01/89	$566.50	$390.00	$370.50	$473.00	$370.50	$176.50	$2,347.00
Sep/01/89	$566.50	$390.00	$370.50	$473.00	$370.50	$176.50	$2,347.00
Oct/01/89	$566.50	$390.00	$370.50	$473.00	$370.50	$176.50	$2,347.00
Nov/01/89	$622.50	$429.00	$407.50	$520.00	$407.50	$193.50	$2,580.00
Dec/01/89	$622.50	$429.00	$407.50	$520.00	$407.50	$193.50	$2,580.00
Jan/01/90	$622.50	$429.00	$407.50	$520.00	$407.50	$193.50	$2,580.00
Feb/01/90	$622.50	$429.00	$407.50	$520.00	$407.50	$193.50	$2,580.00
Mar/01/90	$622.50	$429.00	$407.50	$520.00	$407.50	$193.50	$2,580.00
Apr/01/90	$622.50	$429.00	$407.50	$520.00	$407.50	$193.50	$2,580.00
May/01/90	$927.50	$581.50	$581.50	$770.00	$581.50	$283.50	$3,757.50
% Change	542.78%	346.15%	346.15%	450.61%	346.15%	503.28%	412.40%

Prepared Statement of Senator Steve Symms

Mr. Chairman, this is an issue of great concern and I appreciate you holding these hearings so that we might focus more clearly on the pertinent facts.

Health care has been a priority in Congress for several years. The problems are fairly easy to determine; however, solutions to these problems are extremely difficult to achieve. Even the smallest of changes to the current system directly impacts several different areas.

I do not hold the view that health care in the U.S. is inferior to other countries. Medical and scientific technology have given us state-of-the-art equipment and knowledge and, to a great extent, reduced human suffering. This country has virtually the best health care in the world—if you can afford it. That is the key phrase here. There are too many who cannot afford it.

The *cost* of health care is an issue which must be addressed; however, it is a separate issue from *access.* Often in various proposals, these issues are meshed together into an "omnibus" solution. This approach seems ineffective; these issues must be addressed individually. There are many people in the country who can afford health care, but do not have access. Similarly, many receive quality care within their community, free of charge. Clearly, cost containment will not improve access and vice versa.

We must also make the distinction between *insurance* and *services.* The cost of health insurance is a different matter than the cost of health services. Further, when we discuss lack of access, are we meaning access to services or access to insurance? Obviously, it becomes a complex situation.

I am very interested to hear from our witnesses how they perceive the problem and their suggestions for possible solutions.

Prepared Statemе4nt of Walter F. Williams

I appreciate the opportunity to appear before this Committee to share Bethlehem Steel's views and concerns about the health care crisis facing our nation—an issue far broader than steel industry concerns—an issue affecting both the public and private sector—an issue affecting everyone in some way in our country.

We all must face the fact that our nation's fragmented health care system is simply not working. It is not meeting the needs of the American people by providing affordable, quality and efficient care to all of our citizens.

Simply put—can our society afford the out-of-control health care costs that are double and triple the rate of inflation year after year? The answer is "no"!

The facts speak for themselves:

- Health care costs in 1990 were 12.4% of GNP—more than $675 billion, or about $2,500 for each and every American,
- If current rates of cost increases continue, these costs could represent 25% of GNP by the year 2000, and
- In spite of all this spending, we still have over 30 million people uninsured.

As to the business sector, 1990 was a disaster—with health care costs for private employers increasing an average of 21.6%. Worse yet, smaller companies experienced increases exceeding 30%.

And, finally, getting closer to home for me, the health care cost charge to the hourly payroll in January, 1991 was $4.12 per hour for the steel industry—that was 15.4% of total employment costs. A decade earlier, in 1981, the charge was $1.49 per hour, or 7.4% of total employment costs. That is an increase of 176% for health care compared to only a 21% increase in all other employment costs for this ten year period.

The bottom line is that our industry's health care costs are now two to three times higher than those for the rest of the world's steel industries.

For example, in 1990, each active hourly steelworker in Canada supported health care costs for active and retired steelworkers of approximately $3,200 per year. By comparison, each American steelworker is burdened with an annual cost of $7,600 for health care costs covering the same group. This is a *staggering difference* when you recognize that steelworkers in the United States and Canada have essentially the same benefit package.

The Canadian example is not unique, and the difference is even greater in many countries—and, unfortunately, the gap keeps widening.

Steel is now an international commodity, and we must compete in the global market—and the global market now includes our domestic market. Already burdened by more stringent environmental regulations than most countries and facing

unfair trade practices by virtually all countries, our domestic steel industry is further—and significantly—disadvantaged by runaway health care costs. Especially disturbing is the fact that our customers face the same problem.

To give you a better perspective of my personal concerns, consider these Bethlehem Steel numbers:

- We provide comprehensive medical coverage for our 30,000 active employees.
- Right or wrong, as a result of labor negotiations many years ago, we also provide similar coverage for 70,000 retirees.
- Adding to these numbers the dependents and spouses of these two groups, we presently provide medical coverage for a total of about 170,000 people—all being carried by a current workforce of just 30,000 employees.

Similar numbers apply in varying degrees to others in manufacturing—another good reason for us to be concerned.

Fully recognizing the problem years ago, Bethlehem and other steel companies have not been standing still. In recent years, we've increased employee cost sharing and implemented extensive managed care programs to control rising health care costs.

Unfortunately, these efforts represent "bandaids" which only momentarily slowed down the escalation in cost. They do not—and cannot—attack the underlying inflation which is driven by uncontrolled increases in charges by medical providers.

Even though Bethlehem's health care plans include the full range of managed care programs, we saw our costs rise by 26% in 1990 from $162 million in 1989 to $205 million in 1990. About one-half of the increase was due to increased costs for retirees, and the balance, or an increase of about 13%, was due to escalating medical service costs for all covered personnel.

One final comment on industry's health care costs. I am concerned, as I know you are, about the need to provide access to the 30+ million Americans who do not now have health insurance. We need to expand access, but, we *must,* at the same time, control costs, and address quality.

The principles of cost, access, and quality are interdependent. Failure to address access without addressing cost and quality will not solve our health care crisis—and it could significantly worsen it.

Currently, the private sector does not have a level playing field in health care. Cost-shifting has devastated the private sector employers, both large and small. In fact, cost-shifting may be the most important factor in the destabilization of the U.S. health care system. Without fundamental reforms—that benefit all health care payers—cost-shifting can only make matters worse.

Obviously, as we look back and look ahead, we in the steel industry fully recognize that something must be done—and done now! Joining us is a growing national consensus that the American health care reimbursement and delivery system must be changed.

In short, our health care system is in crisis! We have a systemic problem that requires a systemic solution that, I believe, can only be addressed at the national level. If we are to expand access and control costs, then, I'm convinced we must accept the need for a stronger Federal role in health care.

Our national goal should be to restructure our health care system to insure a healthy society for all Americans at affordable costs.

We, at Bethlehem Steel, believe that a national solution should be consistent with the following principles addressing cost, access, and quality:

1. First, Federal cost containment legislation is needed to insure that public and private payers pay the same for health care. Regional reimbursement schedules for hospitals and physicians should be established to insure that all payers—pay the same—for the same care. Disruptive cost-shifting must be eliminated.
2. Second, national spending targets should be established at the Federal level to reduce annual increases in health care costs to an acceptable level.
3. Third, to address the problem of the uninsured, companies not providing health care for their employees should be encouraged to do so through the use of tax incentives or penalties.
4. Fourth, actions to address the quality of health care should include: the development of practice protocols—technology assessment—quality measurement systems—and continuous quality improvement processes in health care.
5. Fifth, Federal legislative reform is needed to reduce the explosion in costs associated with medical malpractice suits.
6. Sixth, Medicare must remain as the primary payer for the elderly.
7. Finally, *immediate action* on reforms is needed now—even though implementation may extend over a period of several years.

The bottom line is that we must have across-the-board reform. Competitive market forces have not worked to control costs and provide access and bandaid solutions like the multitude of managed care programs have been only modestly effective, as they do not address the underlying price driven inflation in health care.

Bethlehem recognizes the need to work with others who seek fundamental solutions to our national health care crisis. We are working with the National Leadership Coalition for Health Care Reform, the United Steelworkers of America, and other groups to build a coalition for advocating comprehensive restructuring of our health care system to improve quality, increase access and control costs.

But, we need help, so I urge Congress—in this session—to direct its attention to comprehensive health care legislation. Please do not address the problem on a piecemeal approach. It will not solve the problem, as the problems of cost, access, and quality cannot be addressed separately. Obviously, the status quo in health care is no longer an acceptable alternative, so I urge the Congress to place health care high on its agenda for action.

Thank you for the opportunity to meet with you this morning.

Communications

Statement of the American Society of Internal Medicine

Introduction

The American Society of Internal Medicine (ASIM), representing over 25,000 physicians nationwide that are subspecialists in adult medical care, appreciates the opportunity to submit written comments for the record of the April 9, 1991 hearing of the Senate Finance Committee on the Problem of Rising Health Care Costs and Lack of Access to Health Insurance. ASIM has identified: 1) a comprehensive system for expanding access to health insurance for all Americans that closely parallels the Pepper Commission recommendations; 2) appropriate cost-containment initiatives; and 3) a responsible and necessary financing mechanism to accomplish these ends. This written statement is limited to a discussion of ASIM's recommendations for improving access to health insurance and initiatives to help control the rising costs of health care. For those members of Congress who are interested in ASIM's financing proposals, please contact ASIM's Washington Office at 202-289-1700.

ASIM's Recommendations for Expanding Access to Health Insurance for All Americans

1) Congress should require businesses to provide health insurance to their workers and their dependents. Although ASIM believes that such a mandate is the most effective approach to expanding job-based health insurance, ASIM can also support giving employers the option of purchasing coverage for their employees and dependents or paying a tax, per employee, so that the government can provide necessary coverage (i.e. the "play or pay" approach recommended by the Pepper Commission).

ASIM believes that the Congress should build on the strengths of the existing system rather than scrapping it entirely as some have suggested. Despite the obvious inequities in the existing health care delivery system, the fact remains that the U.S. offers the best health care in the world and the system works well for a majority of Americans. Over 65 percent of Americans get their insurance through an employer and nearly 20 percent of all Americans get some form of public assistance with medical expenses.

2) Congress should enact comprehensive reforms to make insurance coverage more affordable and available to all employers. Priority attention should be given to small businesses who simply cannot afford to provide coverage to workers and their dependents or are unable to get insurance coverage entirely. Such initiatives should include: 1) insurance market reforms; 2) specific insurance reforms targeted at the small group market, including the establishment of rating and renewal standards modeled after the recommendations of the National Association of Insurance Commissioners (NAIC); 3) the development of a federally-mandated basic benefit package and the pre-emption of state mandates; 4) appropriate phase-in of mandatory employer coverage to help smaller businesses adjust to the new requirement that they provide coverage; 5) federal subsidies; 6) full tax deductions for the costs of health insurance for small-employed individuals and small business owners; 7) the creation of reinsurance mechanisms; and 8) appropriate cost-containment initiatives.

Insurance Market Reforms

Efforts to make insurance more affordable and available to employers, specifically to small firms, by reforming the insurance marketplace are necessary and should be enacted by Congress this year. Specifically, the Office of Technology Assessment estimates that 20 percent of all Americans who apply for health insurance face pre-existing condition limitations resulting in either increased premiums or exclusions from coverage entirely. Prohibiting exclusions for pre-existing

conditions would help reduce the numbers of uninsured and go a long way toward eliminating the problems of underinsurance--thereby closing a major gap in the present insurance system.

A significant problem characteristic of the small group market in particular--stimulated by intense competition among insurers for business--is the practice commonly referred to as "low-balling." Insurers offer employers initial deep discounts to capture and retain their business. The insurance companies are able to offer these lower-than-average initial rates very easily through medical underwriting--a process by which insurers can assess how healthy the group is before they accept it for coverage. Unfortunately, this rating method often leads to very steep rate increases (sometimes as high as 200 percent) at time of renewal, unless the small group can re-qualify with a different carrier for another select (discounted) rate. Another insurance market practice that has made it particularly difficult for small employers to acquire affordable insurance is experience rating--meaning that based on projected utilization, each employer is assigned to a rating tier. The premiums for employers in each tier are a percentage of the average premiums for groups with similar demographic characteristics in the entire small group pricing pool. Thus, rather than having healthy subscribers helping to subsidize unhealthy subscribers--by spreading risks across all subscribers--unhealthy subscribers must carry their own weight. For employers with workers who have health conditions that incur high medical costs, this often leads to cost-prohibitive insurance premiums or cancellation of coverage entirely.

To correct these abusive rating practices, ASIM urges Congress to ban experience rating entirely to help protect all employers and their workers. Instead, insurers would set rates based on the characteristics of an individual carrier's insureds--meaning that all employers with an insurance carrier would be charged the same rate or two rates based solely on family status. Although ASIM prefers this complete ban on experience rating, ASIM could support the more conservative recommendations of the National Association of Insurance Commissioners to correct abusive rating and renewal practices as an interim step. Specifically, ASIM supports reforms: 1) to establish standards limiting annual renewal rate increases for small groups; 2) to prevent insurers from offering "deep discounts" or select rates in an effort to attract new business by establishing standards on the amount initial rates can vary from average premium rates; and 3) to establish standards on the amount that average premium rates can vary among different classes of business.

ASIM also supports the immediate enactment of a requirement that all insurers "guarantee acceptance" of all small employers wishing to purchase insurance, that insurers disclose their rating and renewal practices to small employers and consumers, and that insurers be prohibited from canceling or failing to renew coverage of a small employer.

3) Congress should convert the Medicaid program from a "welfare program" to one that provides adequate, consistent coverage to any American, regardless of income or locale, who cannot obtain coverage through an employer. Specifically, national uniform eligibility standards for all program participants should be mandated as well as a standard minimum benefit package.

Without an expansion in Medicaid or the creation or a comparable public program to provide coverage for all remaining uninsured, approximately 14 million of the uninsured would still be without access to health insurance.

ASIM's Opposition to a Single-Payer System of Health Insurance

While ASIM supports building on the strengths of the existing system of health insurance, some have advocated that we scrap the current system of private/public insurance and adopt a single-payer system similar to Canada's health care system. Although the specifics of single-payer proposals vary, they have one common element--the creation of a national insurance program primarily funded by the federal government. ASIM strongly opposes any effort to discard the existing public/private system of insurance that provides coverage to 80 percent of employees and their dependents and substituting a single-payer approach. Mandating employer coverage would provide insurance to all but one-fifth of the uninsured, with the remaining uninsured getting coverage through the public program. Additionally, our approach, as well as that of the Pepper Commission, has captured broad public support, is politically feasible and fiscally responsible. ASIM objects to the single-payer approach for the following reasons:

- Under a single-payer approach Americans health care would be at greater risk to competing budget priorities and restricted access to needed services;

- Concentrating the financing of health care in the hands of one payer eliminates choices for patients as well as employers;

- According to recent public opinion polls, building on the current health care insurance system is what the American people want; and

- Considering the massive federal deficit, it is fiscally irresponsible to propose a single-payer system which could cost upwards of $250 billion. The public is unwilling to pay the amount needed in increased taxes to support such a massive entitlement.

The Administrative Costs of Insurance

Support for a single-payer health care system largely stems from a perception, or rather a myth, that under a single-payer system this country could save billions of dollars--as high as 22 percent of all health care costs--which could be used to expand access to America's 30 million uninsured. This myth is based on a 1986 estimate that 22% of all heath care spending goes to the costs of administration, which proponents of a single-payer system often contend, is generated by a system of multiple payers. While no one can be against eliminating waste and inefficiency, the argument that almost a quarter of all health care spending is wasted on administration, which would suddenly disappear under a single payer national health insurance system, is unsubstantiated.

The source of this argument is a 1986 "Sounding Board" article that appeared in the New England Journal of Medicine. Unfortunately, although everyone cites the study's estimate of administrative waste, very few people seem to have taken a hard look at the assumptions underlying the article. The article, "Cost Without Benefit: Administrative Waste in U.S. Health Care", authored by David Himmelstein, MD and Steffie Woolhandler, MD, does not stand up to critical scrutiny. To put it simply, the article does *not* support the contention that 22% of health care spending represents administrative waste. It does *not* show that anything close to that amount of money can be saved by going to a single payer system. What it *does* attempt to do is construct an argument that substantial savings would occur if a Canadian-style system were adopted. But even there the

assumptions and data used to support that contention are so suspect that it is hardly the authoritative source one might have expected given how often it is presented as fact. In arriving at the 22 percent figure, Himmelstein and Woolhandler factored in *all* overhead--including money spent on the overhead costs of running a hospital, nursing facility, or physician office such as the costs to hire a receptionist who answers the phone in a doctor's office, the cost of renting office spent, the cook who prepares meals for patients in nursing homes, quality assessment initiatives, risk management programs and registration fees for continuing medical education--that is incurred in the health care delivery system. The only way to eliminate the alleged 22% of health care spending that supposedly goes toward administration would be to get rid of all this overhead. It is absolutely clear, however, that this is impossible. For under a single-payer system many of these costs would still be incurred. In light of these facts, the notion that we can save nearly a quarter of all health care spending by eliminating wasteful bureaucracy is reduced to a myth.

Overhead expenditures in the U.S. are higher than in some countries that have adopted a single payer NHI plan, for a variety of reasons that Woolhandler and Himmelstein did not consider. Differences between the countries that are totally unrelated to the payment system are likely to be a factor. Therefore, it is not necessarily true that adoption of a single payer NHI plan in the U.S. would lower administrative costs to the degree assumed by Woolhandler and Himmelstein and claimed by proponents of the single-payer system. One important factor is that the U.S. spends more on quality assurance in this country, such as Joint Commission on Accreditation of Health Organizations' accreditation standards, peer review organizations, hospital tissue committees, continuing medical education requirements, specialty certification and recertification requirements, hospital credentialling, the National Practitioner Data Bank, current and proposed clinical laboratory accreditation. Additionally, Americans are more litigious than people in other countries. This requires hospitals and physicians to spend more money on legal fees, premiums, risk management and documentation. These costs would not evaporate in thin air under a single-payer system.

A 1991 Congressional Budget Office Report titled "*Rising Health Care Costs: Causes, Implications and Strategies*" states that in 1987 the administrative costs associated with the multiple insurance system alone were $23.9 billion, or 4.9 percent of health care spending in the U.S. as opposed to the 22 percent claimed by proponents of a single-payer system. This same report also indicated that the U.S. is doing a much better job of controlling the level of per capita spending on health care compared to Canada, which has adopted a single-payer system. Over a seven year period (1980-87), real per capita spending of health care in the U.S. increased 33 percent. By comparison, Canada's increase in real per capita spending was 38 percent.

Appropriate Ways to Contain Administrative Costs

Regardless of the fact that this country is clearly not spending 22 percent of all health care dollars on administration, every effort should be made to make the health care system as efficient and cost-effective as possible. ASIM has developed ways to reduce the administrative costs of insurance as opposed to abandoning our multiple payer system. As part of ASIM's hassle factor campaign, for example, ASIM has proposed several measures that would streamline, reduce, or eliminate unnecessary hassles--and the administrative costs that they generate for physicians, hospitals, nursing homes, and insurers.

ASIM's recommendations to reform the health insurance industry, particularly for small employers, also hold the promise of substantially reducing administrative costs, by introducing greater uniformity in the insurance industry and eliminating discriminatory rating and marketing practices. Community rating, for example, would eliminate the need to hire staff to do underwriting. Similarly, federalization of Medicaid's benefits, eligibility and reimbursement would reduce administrative costs that now occur when individuals move from one state to another and become subject to different requirements and paperwork. Professional liability reform can also cut overhead associated with high premiums, legal fees, excessive documentation requirements and risk management.

ASIM urges the Congress to enact legislation requiring insurance carriers to fully disclose the portion of health care premiums that is spent on administration, specifically with a breakdown of the percentage of premium dollars that is allocated to marketing, claims processing, other administrative expenses, profits, reserves and payment for covered benefits. This requirement accomplishes two goals: 1) policyholders will have access to important information that can be used comparatively and 2) full disclosure could result in increased competitiveness in the market and may encourage insurers to hold down administrative and marketing costs.

Given the growing consensus for requiring employers to offer health insurance and expanding the public programs to fill the remaining gaps, it is counterproductive to continue the debate over the appropriateness and feasibility of a single-payer system in the U.S. Rather than forwarding action on the problems of the uninsured, the continued debate over whether this country should have a single health care financing source or multiple sources holds this country in a grid lock delaying long-awaited and needed action.

Cost-Containment as a Component of Any Access Legislation

ASIM recognizes the need to include cost-containment measures in access legislation. That is why ASIM has gone to great lengths to identify and go on record in support of a number of far-reaching measures to contain costs, including efforts to reduce the administrative costs of insurance, selective contracting for certain high-cost elective procedures (so-called "centers of excellence), practice guidelines linked to utilization review, insurance market and professional liability reforms, cost-sharing varied by income and type of service and measures to decrease physician and public demand for technologies of unproven benefit. ASIM also recently developed several additional policy recommendations for containing costs.

Briefly, ASIM supports: 1) continued efforts to develop scientific data that assesses what managed care techniques–including prior authorization, pre-admission review, preferred provider arrangements, utilization review, pre-procedure review and capitation plans–are effective in controlling costs and maintaining quality; 2) efforts to reduce health care costs associated with fraud and abuse (such as strengthening the power of state disciplinary boards and providing immunity for physicians who report colleagues who are suspected of violations); 3) appropriate efforts to reduce health care costs associated with incompetent and impaired physicians; 4) efforts to develop and encourage employers to purchase benefit packages that include wellness care, including the development of scientifically valid evidence that wellness programs are cost-effective; and 5) the development of a Medicare PPS for hospital capital costs that promotes efficiency in capital investments and maintains access to high quality hospital care for Medicare beneficiaries.

Recommendations for Reducing Inappropriate Demand for Expensive Medical Technology

Additionally, the high costs of existing medical technologies and the explosive growth in the development of new technologies must be addressed. National news coverage of a new technology or procedure often causes patients to place considerable pressure on their physician to perform a test or procedure even when the physician does not believe it is necessary or beneficial. Unfortunately, new technologies often receive widespread news coverage even in the early stages of development and before they have been proven effective. ASIM is committed to communicating with the press about the importance of reporting on technological advancements in a way that informs the public that studies are preliminary and that it may be too early to determine the effectiveness of a new medical procedure, specifically when the evidence is inconclusive.

Just as physicians have a responsibility to educate their patients about the effectiveness of a new or modified technology in curing an illness, physicians have a responsibility not to order or provide technology that is not yet proven to be beneficial or is not medically indicated. ASIM will be developing materials that can be used by physicians to explain to their patients why certain highly-publicized technologies or procedures of unproven benefit may not be in their interest, and will be encouraging other professional organizations to do the same.

Comprehensive action is required for assessing technologies before they become a part of common medical practice. Currently, many new and expensive technologies find their way into common medical practice without having been evaluated adequately to ensure quality, appropriate use and cost-effectiveness. Technologies are largely evaluated and assessed after they are on the market and not before the medical procedure or equipment becomes part of common medical practice. Before prescription drugs and some medical devices are marketed and used, they must be tested, and the evidence regarding their safety and efficacy (although not their cost-effectiveness) must be reviewed by the Food and Drug Administration (FDA). Many new technologies and most medical procedures do not have to undergo similar formal tests. They can be commonly used without convincing evidence that they are effective or cost-efficient.

To address this issue, efforts should be undertaken to explore the creation of a private or governmental review body to prospectively assess new technologies and procedures. This approach should utilize an un-biased panel of expert physicians to assess new technologies and procedures before they become a common part of medical practice. The review body should only evaluate, not approve and disapprove, the safety, effectiveness and cost-effectiveness of technology before it becomes a part of common medical practice. In this way, the review body would act as an advisory group to the public, media and physician community to provide appropriate and accurate information on the safety, effectiveness, cost-effectiveness and appropriate use of new medical technology and procedures.

The innovators of new technology and medical procedures should be encouraged to apply to the review body for evaluation but the process should not impose unreasonable regulatory burdens that may discourage creativity and innovation in the development of technology. Unreasonable delays in the use of technologies could result in financial disincentives in the development of new technology resulting in reduced investment in research and development. Such a prospective review process should not replace ongoing efforts to assess technologies and medical procedures that have already become a part of common medical practice. Efforts to assess

existing technologies and medical procedures to ensure the technologies and medical procedures are demonstrated to be safe, effective and cost-effective are necessary.

ASIM Opposition to "All-Payer" Approaches

ASIM is concerned with the apparent direction some members of Congress are considering in the area of cost-containment--namely the "all-payer" system of insurance--and believes that Congress should give the above cost-containment recommendations an opportunity to demonstrate their effectiveness before considering this approach. Many of the approaches being considered by Congress would base payments under an all-payer system on the Medicare RBRVS fee schedule. All payers could simply be required to use the Medicare fee schedule. Alternatively, they could be required to pay within a specified range of the Medicare fee schedule (e.g. private insurers could be limited to paying no more than 125 percent of the Medicare fee schedule amount). They could be required to pay at a set fee for all services, or they could be allowed to pay different amounts up to a set ceiling. Insurers, for example, could be required to set their reimbursement levels at 125 percent of the Medicare fee schedule amount, or they could be allowed to vary their payment levels as long as they do not exceed 125 percent of the fee schedule. Acceptance of balance billing limits would be mandatory.

A variation of a mandatory all-payer approach is to establish strong incentives for employers and insurers to pay at the specified rates, and for physicians to accept those rates, and creating penalties for those who do not agree to payment at the specified rate. For example, some members of Congress are considering linking physician participation in public programs with acceptance of uniform rates in the private sector.

ASIM *strongly objects* to these approaches for the following reasons:

1. Basing payments by private insurers on Medicare rates places all health care at risk to federal budget policy. The likely result will be to significantly discount payments for physician services, thus threatening access to services. Over the past decade or so, Medicare's payments for physicians' services have been repeatedly cut in an effort to reduce the federal deficit. Fee freezes, caps on prevailing charges, reductions in the Medicare economic index, and overpriced procedure cuts have all been utilized. More cuts are likely to be in store for the future. As a result, Medicare's "rates" are a substantial discount from what physicians actually charge, what most private insurers reimburse, and what would be a fair fee based on resource costs and competition. In essence, physicians have been able to cope with these cuts by shifting costs to their privately-insured patients.

ASIM recognizes the political attractiveness of eliminating cost-shifting by making it difficult or impossible for physicians to bill their private patients in excess of Medicare's rates. But the gap between what Medicare pays (and is likely to pay in the future), and what is a fair fee, is so great that limiting payments under private insurance to some percentage above Medicare rates would wreak economic havoc on many physician practices, specifically primary care physicians in rural areas.

2. Access to primary care will be especially hurt if Medicare's rates are used to determine payments in the private sector. Even with the expected increases in payments for "primary care" services under the new Medicare RBRVS fee schedule, Medicare payments are likely to still be substantially below what primary care services are reimbursed under private insurance, and what

primary care physicians charge in the private marketplace. Use of Medicare's rates to determine private payments, even with RBRVS, would result in a substantial cut in revenue for many primary care physicians. From what ASIM hears everyday from primary care physicians, many could simply not afford to stay in practice if forced to absorb deep reductions in overall revenue. Widespread use of Medicare's approved rates will drive many primary care physicians to early retirement and discourage new physicians from going into primary care.

By comparison, higher paid specialties may be more able to absorb reductions in revenue (a 25% cut in gross revenue for a primary care physician earning net $90,000 [reduced to net $52,500], for example, is far more devastating than a 40% reduction for a physician now earning $500,000). Common sense tells us that physicians will go into those specialties that will be able to financially withstand the consequences of an "all payer" system, rather than going into the increasingly precarious primary care specialties.

ASIM supports the voluntary use of the RBRVS methodology to establish rates in the private sector. But tying reimbursement to a percentage above the conversion factor used by Medicare, or to Medicare's actual conversion factor, represents a *betrayal* of what the RBRVS is all about.

3. Given that the effects of Medicare's new fee schedule, which won't go fully into effect until 1996, are highly uncertain, it clearly is premature and risky to base private payments on Medicare rates. The new Medicare fee schedule incorporates a number of highly controversial policies, including tight balance billing limits, elimination of specialty differentials, volume performance standards, and a major redistribution of across geographic boundaries. Although ASIM expects that these policies (with a few exceptions) will prove to be beneficial for Medicare, the magnitude of the reforms are such that no one knows with certainty what their impact will be. Just to cite one example, physicians in some metropolitan areas will have their Medicare fees--and revenues--cut substantially. Congress was sufficiently concerned about how access would be affected by such cuts that it added a requirement in OBRA 90 that HHS study the factors that may cause certain geographic areas to experience disproportionately large reductions in payments under the RBRVS fee schedule, and report to Congress on appropriate adjustments. If physicians in those communities are now required to absorb severe cuts in total revenue from all sources, it is possible that they may have no choice than to relocate their practices. Access to care in those communities might then be severely impeded.

4. Federal legislation that pressures insurers, businesses, and physicians to limit payments to a set percentage of Medicare's rates represents an unprecedented federal intrusion into the right to contract, particularly the right of businesses, individuals, and physicians to enter into whatever payment arrangement best meets their particular needs. In no other area of the economy does the federal government presume to tell private individuals what it believes to be the correct price for services offered in the marketplace. Pressuring private individuals to use Medicare's rates raises not only grave constitutional and legal issues, but represents an unwarranted and unprecedented departure from free market principles that are basic to American society.

Finally, overt incentives for private plans to base their payments on Medicare rates could weaken, and quite probably destroy, the growing consensus for access legislation based on the Pepper Commission recommendations. Physician organizations such as ASIM have been strong proponents of universal access legislation based on the Commission's approach. Inclusion of an "all payer" approach, even if modified to stress incentives (rather than mandates) for private insurers to establish payments based on the Medicare rates, could trigger considerable opposition

within the physician community to access legislation. The degree of concern about this approach is evident by the fact that use of Medicare rates by private insurers was explicitly rejected by the Pepper Commission. If this country has any hope of moving access legislation forward within the next few years, it makes no sense to include measures that will polarize the debate, divide the groups supporting reform, and make enactment less likely. It is counterproductive to propose an a modified all-payer plan now that would move the objective of enacting comprehensive access with appropriate cost controls backwards, not forwards.

Conclusion

Now is the time for comprehensive access reform legislation to shore up the gaps in our existing system of health insurance. *Now is the time* to initiate efforts to control the rising costs of health care. Our approach, as well as that of the Pepper Commission, accomplishes both objectives and has captured broad public support, is politically feasible and fiscally responsible. We stand ready to help Congress enact these necessary reforms.

Summary of Recommendations on the Problem of Access to Health Insurance

1) Congress should require businesses to provide health insurance to their workers and their dependents. Although ASIM believes that such a mandate is the most effective approach to expanding job-based health insurance, ASIM can also support giving employers the option of purchasing coverage for their employees and dependents or paying a tax, per employee, so that the government can provide necessary coverage (i.e. the "play or pay" approach recommended by the Pepper Commission).

2) Congress should enact comprehensive reforms to make insurance coverage more affordable and available to all employers. Priority attention should be given to small businesses who simply cannot afford to provide coverage to workers and their dependents or are unable to get insurance coverage entirely. Such initiatives should include: 1) insurance market reforms; 2) specific insurance reforms targeted at the small group market, including the establishment of rating and renewal standards modeled after the recommendations of the National Association of Insurance Commissioners (NAIC); 3) the development of a federally-mandated basic benefit package and the pre-emption of state mandates; 4) appropriate phase-in of mandatory employer coverage to help smaller businesses adjust to the new requirement that they provide coverage; 5) federal subsidies; 6) full tax deductions for the costs of health insurance for self-employed individuals and small business owners; 7) the creation of reinsurance mechanisms; and 8) appropriate cost-containment initiatives.

3) Congress should convert the Medicaid program from a "welfare program" to one that provides adequate, consistent coverage to any American, regardless of income or locale, who cannot obtain coverage through an employer. Specifically, national uniform eligibility standards for all program participants should be mandated as well as a standard minimum benefit package.

4) ASIM strongly opposes any effort to discard the existing public/private system of insurance that provides coverage to 80 percent of employees and their dependents and substituting a single-payer approach. Given the growing consensus for requiring employers to offer health insurance and expanding the public programs to fill the remaining gaps, it is

counterproductive to continue the debate over the appropriateness and feasibility of a single-payer system in the U.S.

Summary of Recommendations on the Rising Costs of Health Care

1) ASIM supports several far-reaching measures to contain costs including: **a**) efforts to reduce the administrative costs of insurance; **b**) selective contracting for certain high-cost elective procedures (so-called "centers of excellence); **c**) linking practice guidelines to utilization review; **d**) insurance market and professional liability reforms; **e**) cost-sharing varied by income and type of service; **f**) measures to decrease physician and public demand for technologies of unproven benefit, including retrospective technology assessment; **g**) the enactment of legislation to require insurance carriers to fully disclose the portion of health care premiums that is spent on administration, specifically with a breakdown of the percentage of premium dollars that is allocated to marketing, claims processing, other administrative expenses, profits, reserves and payment for covered benefits; **h**)continued efforts to develop scientific data that assesses what managed care techniques--including prior authorization, pre-admission review, preferred provider arrangements, utilization review, pre-procedure review and capitation plans--are effective in controlling costs and maintaining quality; **i**) efforts to reduce health care costs associated with fraud and abuse (such as strengthening the power of state disciplinary boards and providing immunity for physicians who report colleagues who are suspected of violations); and appropriate efforts to reduce health care costs associated with incompetent and impaired physicians; **j**) efforts to develop and encourage employers to purchase benefit packages that include wellness care, including the development of scientifically valid evidence that wellness programs are cost-effective; **k**) the development of a Medicare PPS for hospital capital costs that promotes efficiency in capital investments and maintains access to high quality hospital care for Medicare beneficiaries; **l**) efforts to explore the creation of a private or governmental review body-made up of un-biased expert physicians--to prospectively assess new technologies and procedures; **m**) efforts to communicate with national science writers the importance of reporting the limitations and inconclusive nature of some medical studies on new technological advancements; and **n**) efforts to educate physicians of their responsibility not to order technologies of unproven benefit.

ASIM believes these cost-containment approaches should be given an opportunity to demonstrate their effectiveness before Congress makes a decision to adopt an all-payer system of insurance.

tz/sen.fin

Statement of the Association of Minority Health Professions Schools

BACKGROUND STATEMENT

The Association of Minority Health Professions Schools (AMHPS) strongly supports reform of our national health care system which insures health care services to anyone who needs access to health care. Disparities in access to health care is the dominant factor which accounts for the growing disparity in the health status between blacks and other disadvantaged minorities and the general population of the U.S. Improved access to health care is of paramount importance in achieving the AMHPS mission to improve the health status of minority and disadvantaged persons. National health care reform is absolutely essential in order to address the crises of lack of access to proper health care for minorities. It is important to note that in the last few years policy makers have debated the merits of various health reform plans. The Federal Government must demonstrate leadership by addressing this crises now.

HEALTH CARE REFORM PROPOSALS

Recently, there has been significant debate about various health care reform programs. The current debate has not addressed the crises because no health reform program appears close to being enacted by the Congress. The process for enacting reform appears to have ended before it began. Several reports that attempt to reach a consensus on the best process of health care reform include the Health Leadership Commission which issued two minority reports after two years of consideration.

Once report from Corporate American felt that the Commission's proposal put too much money into the hands of providers, especially physicians, by providing universal access programs with payer pools at the state level. This report felt that more emphasis should be placed on cost containment and less emphasis on increasing access.

Another minority report from the American Medical Association (AMA) which felt that the Leadership Commission's proposal was too critical and too negative about physicians in its analysis of the present health care system. Other reports on this topic, ranging from the National Association of Social Workers to the U.S. Bipartisan Commission on Comprehensive Health Care clearly indicate that there are too many ramifications and too many conflicting political agendas to allow groups with large constituencies to successfully develop a viable proposal. Therefore, we are recommending a different process to developing a health care reform proposal—one in which President Bush and his Secretary for Health and Human Services would define some desired outcomes such as universal access, measures to control cost, and a program to evaluate appropriateness and quality of care as well as some built-in economic and other incentives.

Given the defined objectives or desired outcomes, a group of people should be brought together based on their technical skills and not their representativeness of different organizations or constituents. Given their technical skills, they should be asked to develop a system that would best provide the outcomes which have been defined and, at the same time, have a measure of political feasibility built into it. This technical group, or task forces must be politically neutral in coming up with a proposed program or programs.

HEALTH STATUS DISPARITY

Blacks and other disadvantaged minorities do not enjoy the same health status as other Americans. The *1985 Health and Human Services Secretary's Task Force Report on Black and Minority Health* demonstrated that there indeed was and is a significant health status disparity among blacks and other minorities as compared to the general population of the U.S.

Among the more sobering facts revealed by the report were:

- Life expectancy of blacks is nearly 6 years less than that of whites;
- Among blacks, infant mortality occurs at a rate of almost 20 per 1,000 live births, twice that of whites;
- Blacks suffer disproportionately higher rates of cancer, cardio-vascular disease and stroke, chemical dependency, diabetes, homicide and accidents; and
- Each year almost 60,000 excess deaths occur 'among blacks when compared to whites.

Since this historic report by the Secretary in 1985 the health status gap has widened. The National Center for Health Statistics recently reported that black life expectancy has decreased from 69.7 in 1984 to 69.2 in 1988. AIDS, which was not even

mentioned in the 1985 report is now a leading cause of death and disproportionately affects blacks and other minorities—minorities who constitute 24 of the U.S. population but 45% of our AIDS victims.

AMHPS INSTITUTIONS

AMHPS is comprised of 8 historically black health professions schools which have trained 40 of the nation's black physicians, 40% of the nation's black dentists, 50% of the nation's black pharmacists, and 75 of the nation's black veterinarians.

AMHPS institutions each has a student body that is represented by more than 50% minorities. Yet while blacks constitute 12 percent of the population, only 3 percent of physicians are black and only 5 percent of medical school graduates (since 1980) have been black. This is important in that data clearly show that blacks and other minorities are more likely to practice in underserved communities, more likely to care for other minorities and more likely to accept patients who are Medicaid recipients or otherwise poorer than the general population. While the Federal government's commitment to supporting historically black health professions schools is beginning to address the disparity in health status between minority and non-minority populations, AMHPS believes that in addressing the enormous problem of this health status disparity, a firm commitment from the Federal Government to the *users* and *payers* of health services must be made.

AMHPS institutions have been at the vanguard of addressing the enormous need to close the gap in the health status disparity between the minority and majority populations, to increasing the number of minorities in the health professions and to serving the indigent and the underserved. There is a direct correlation in between these objectives and the causes of these problems which gave rise to our institutions' objectives. These objectives all emanate from the historical and tremendous problem of disparities between minority and majority populations in access to health care. For many years our institutions have been involved in minority health professional education and have established an outstanding track record in serving the underserved.

Yet these institutions have paid a price for their missions and their commitments. While the average medical school gets 40 percent of its revenue from patient care, the minority medical schools often lose money in patient care due to the fact that the majority of their patients are usually poor. As access problems worsen for the poor, these institutions' plights also worsen. Cutbacks in Medicaid and Medicare, in the 1980's, severely impacted these institutions and their related hospitals. The overwhelming majority of historically black hospitals closed during the 1980s, and the approximately ten remaining are all suffering from deficit operations. The medical education programs have likewise suffered. Recently, a Council of Graduate Medical Education (COGME) report demonstrated that many academic health centers have suffered a significant decline in their operational margins during the 1980s. It is clear that those that are involved most heavily in the care of the poor now have negative margins that are continuing to decline.

HEALTH CARE REFORM IS URGENT

There are approximately 37 million Americans who have no health insurance. Millions of disadvantaged Americans are not able to pay and receive health care. Employers who do provide health insurance, public hospitals and people with health insurance subsidize the costs of uncompensated care. The current situation is unacceptable and demands urgent action by the Federal government. Every day that health care reform is delayed, more blacks die. Every day that health care reform is delayed, minority health professions institutions experience greater financial instability.

From 1977 to 1987 the relative increase in the number of persons without insurance was greater among minorities than whites. During that time span, the number of uninsured whites increased by about 28 percent while the number of uninsured blacks nearly doubled from four to seven million and the number of uninsured Hispanics increased three-fold from two to six million. Thirty-five percent of Hispanics under age 65 and 26 percent of blacks, were uninsured in 1987 compared to 15 percent of whites. The increase between 1977 and 1987 in the proportion of uninsured Hispanics was five times the increase for whites. For blacks, the increase was twice that for whites. The declining proportion of blacks with health insurance is mainly due to a reduction in private insurance, with public coverage declining.

As the *1985 Secretary's Task Force on Black & Minority Health* revealed, "Many . . . minorities tend to rely on Medicaid and charity care for their medical treatment because they have no other sources of care or ways to finance that

care . . . " Further, minorities are disproportionately poor and unemployed, consequently they disproportionately experience the barriers to health care associated with poverty. Under the current system of health care insurance, poor people are too often excluded from the process. There is a correlation between the problem of criteria for eligibility into the process of health cost reimbursement and the problem of poor access to health care by the poor. Health care coverage is often provided through employment, so for minorities access to health care is often obstructed through unemployment and through employment with businesses such as many of those in the service industry that do not provide health insurance. Many other barriers exist as a result of poverty which prevent access to health care, including lack of available health care personnel, transportation, and other cultural barriers. Economic and other barriers to the receipt of health care must be eliminated.

GENERAL RECOMMENDATIONS

AMHPS believes that the following general criteria are essential elements to any health care reform plan. The plan must provide (1) universal, comprehensive coverage. It must (2) maximize cost efficiency through cost containment and it must (3) maintain a free-enterprise component.

Improved access to health care for all Americans must be the primary component of health care reform. In his January 29th State of the Union address, President Bush stated that "good health care is every American's right and every American's responsibility." Access to health care should not relate to one's ability to pay. The issue must be placed on the national agenda immediately.

National Health Care Reform must also maximize cost efficiency. Health care costs have risen beyond control. The U.S. spends over 600 billion dollars per year on health care. Per capital health spending is greater in the United States than in Canada, yet our nation has a lower life expectancy and a higher rate of infant mortality. A national health care reform program should stabilize health expenditures as a percentage of the national income and reduce the problems of uncompensated care and individual burdens of catastrophic illness. In order to achieve these objectives such a plan must redirect available resources to the weaknesses of the system. Too often, funding that was originally intended to help the indigent does not reach the indigent. The flow of resources to the underserved is not being appropriately applied. A redirection of resources to institutions that provide quality care to the disadvantaged, to the underserved and to the indigent, is an important component of any national health care reform program. There must also be a focus on preventive medicine and primary care.

Finally, a national health care reform program must maintain a free-enterprise component, that would allow for the continued provision of health care services by the most competent and accessible individuals or systems, at the most affordable and reasonable cost.

THE PROCESS

In the last year alone, several major health care associations, as well as the Pepper Commission have developed national health reform programs. Yet without Executive leadership and differences over the various aspects of the several proposals, no work has begun in Congress to enact a new health coverage program. Whether the means toward achieving universal access to health coverage include incentives for employers to provide health care coverage and support for public programs that provide access to basic health care benefits for the uninsured or not, what is important is to recognize that alleviating the problem of the health status disparity between disadvantaged minorities and the general population is crucial.

Black Americans are experiencing a health care crisis. The President and the Congress must exert leadership and enact legislation to improve access to health care for minorities. Action must not be delayed any longer.

Health Insurance:
The Foodservice Industry Perspective

Background Paper

Confronting the problem: the foodservice industry and health care costs

When the U.S. spends nearly 12% of its GNP on health care and at the same time an estimated 31 million Americans remain uninsured, the warning is obvious: Something is seriously awry in the U.S. health care system.

As the leading trade association for the foodservice industry, the National Restaurant Association is concerned about gaps in health care coverage and about runaway health care costs. Foodservice, which employs about 7% of the U.S. workforce, is an industry dominated by small businesses, those often least able to afford to provide health insurance. National Restaurant Association research shows that most foodservice operators would like to offer health insurance to employees — and generally do so, as profits and size increase. However, operators report that the single greatest obstacle to providing insurance is cost.

Foodservice operators are working with Congress to find ways to reduce health care costs so employers who want to provide health insurance can do so. Neither the broad-brush approach of a government mandate nor a tax on employers who already cannot afford coverage are realistic solutions to the problems of uninsured workers. Forcing all American businesses to provide health care benefits, regardless of the cost and without thoroughly reviewing all of the consequences, will in the long run only hurt those Congress is trying to help.

Costs are up dramatically

A recent National Restaurant Association survey shows that the cost for a foodservice employer's share of health insurance premiums rose a minimum of 23% between 1987 and 1989. Some operators experienced increases averaging 60% over that two-year period.

How have operators held up under these financial strains? In addition to bearing the cost of increased premiums, more companies are finding it necessary to require hourly employees to shoulder some of the financial load for health insurance coverage, requiring higher employee contributions to premiums and deductibles and cutting back on benefits.

Like other employers, restaurateurs face limits in the costs they can absorb and still remain viable. While medical costs grow at an alarming rate, entrepreneurs left to cope with that fiscal burden are finding the health of their businesses undermined.

Small businesses have the most difficulty

The Census Bureau reports that in 1987 72% of eating place firms had sales under $500,000 a year. Small firms like these, whose job growth has fueled the U.S. economy since 1982, encounter special difficulty finding and affording health insurance.

Facing a smaller pool of employees over which to spread risks, higher fixed administrative costs and lower profits, small foodservice operators are in no position to exercise cost containment, make substantial contributions to premiums or self-insure to avoid the state benefit mandates that price basic insurance policies out of their range.

In late 1989, the National Restaurant Association polled smaller restaurateurs who do not provide insurance. Among small firms with annual sales of less than $500,000, almost three-quarters said they did not provide health insurance because premiums were too high. Nearly two-thirds of this group said their company was not profitable enough.

Even in light of these problems, however, foodservice operators *want* to provide insurance. Restaurateurs know that in order to attract and keep a loyal and stable workforce, they must offer good benefits. Health insurance is generally one of the first benefits they offer.

Statistics prove the point. As sales volume increases for a foodservice operation, the likelihood of providing health care coverage for both hourly and salaried employees increases. Association research shows that 30% of foodservice companies with annual sales under $500,000 provide insurance for both hourly and salaried employees; the percentage climbs

to 72% for companies with sales between $1 and $5 million a year, and 87% for companies with yearly sales over $10 million. Left to voluntary measures, employers *will* take action.

Percent of foodservice employers providing health insurance coverage for hourly and salaried employees by type of plan and company sales volume, 1989

As sales volume increases, the likelihood of providing coverage for both hourly and salaried employees increases

Type of coverage	Annual company sales: Less than $500,000	$500,000-$999,999	$1 million-$4.9 million	$5 million-$9.9 million	$10 million and more
Hourly employees only	4%	5%	1%	0%	0%
Salaried employees only	15	18	18	21	13
Hourly and salaried employees	30	60	72	75	87
No plan	51	17	9	4	0
	100%	100%	100%	100%	100%

Source: *National Restaurant Association Health Benefits Survey, August 1989*

A mandate is no solution

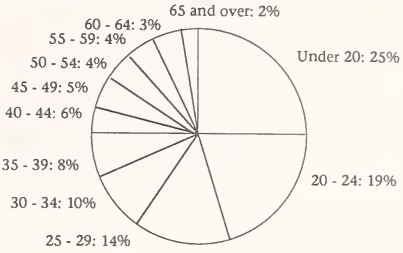
The very characteristics that have made restaurants and other small businesses such a dynamic economic force and the source of millions of entry-level jobs also make them especially sensitive to the cost increases that would be imposed by a mandate.

The foodservice industry employs large numbers of young, inexperienced and part-time workers, many of whom would otherwise be without jobs. The typical foodservice employee is a female (56%), under 30 years of age (58%), unmarried (63%), and living in a household with two or more wage earners, where most of these other earners work full time. Many are dependents who are covered under the health plans of a parent or spouse.

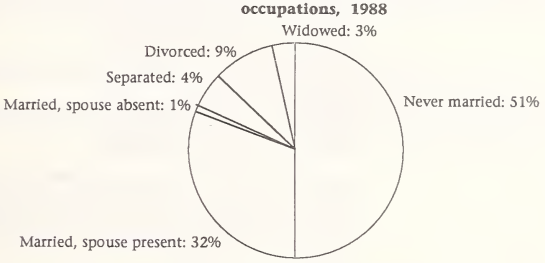
The fact that the typical foodservice employee is likely to be female, young and unmarried means that the average foodservice worker is different in many respects from the average U.S. worker. Furthermore, the average workweek for production employees in eating and drinking places is 26 hours, compared to 35 hours for production workers in private industry.

The typical foodservice employee also has less tenure with his or her current employer. About 40% of foodservice employees have been with their current employer less than a year, versus 28% of all employed individuals.

Age of individuals in foodservice occupations, 1988



Marital status of individuals in foodservice occupations, 1988



Source: Current Population Survey, March 1988 Tape

In short, many of these employees are only marginally attached to the workforce. They may be students with part-time jobs, or second earners who are not interested in full-time work. Employees like these are often looking for part-time or seasonal work that will bring in some extra cash. The foodservice industry has provided this opportunity for millions of American workers, reducing the nation's unemployment rate while at the same time answering these employees' needs for flexible work that gives them the job experience that can boost them further up the employment ladder.

Yet most National Restaurant Association members could not afford to provide these employees with the array of benefits a mandate would require. For small independent restaurateurs already faced with high payroll costs, the additional expense of providing comprehensive

health benefits to all employees — without regard to their productivity — is simply prohibitive. It is hard enough for restaurateurs to provide even a bare bones health plan. The likely result of a mandate would be fewer jobs for these more marginally-attached workers.

Moreover, a mandate removes the choice that is the hallmark of a free market system and forces adult employees to participate in their employer's health care plan regardless of whether they want, need, or can afford the coverage.

Cutting costs the first solution

The National Restaurant Association recommends that lawmakers direct their attention to removing the barriers that discourage employers from providing health insurance. Foodservice operators ask Congress to take the following six steps:

1. Develop cost-containment measures, both long- and short-term.
Establish physician practice guidelines, find ways to eliminate unnecessary procedures and revise medical malpractice laws to reduce liability insurance costs for physicians.

2. Scrutinize the underwriting practices of insurers.
The National Restaurant Association questions the role of the insurance industry in accepting employers' insurance premiums for years and years and then hiking premiums dramatically or cancelling insurance completely when workers file claims.

The government should examine these practices, as well as take action to prohibit insurers from issuing blanket denials of coverage to certain small businesses and occupations that insurers arbitrarily deem risky.

An example of the problem
The Oklahoma Restaurant Association provided group medical insurance to its members, their families and employees for over 20 years. In December 1987, participants were hit with premium rate increases ranging from 32-143%; in August 1988, operators saw increases of 60-82%. On January 1, 1989, the American Fidelity Assurance Company cancelled ORA's master plan, leaving 350 foodservice companies without insurance. People with a history of chronic illness or terminal conditions were unable to find coverage anywhere at any price.

3. Provide favorable tax treatment for employers who provide benefits and individuals who purchase health insurance.

- Allow a full tax deduction for *any* business that provides health insurance, not just corporations. According to the Employee Benefits Research Institute, 22.4% of the self-employed do not have health insurance, a significant portion of the uninsured. The current 25% deduction provides little incentive for self-employed businesspeople to provide coverage for themselves and their employees.
- Provide a refundable tax *credit* to employers for whom a tax deduction yields little advantage. A tax deduction won't encourage companies to provide health benefits if their profits aren't high enough to make a write-off advantageous. A tax credit would provide significant incentives for start-up and less stable businesses to provide insurance.
- Provide a full tax deduction or a partial tax credit to individuals who purchase their own health insurance. This will equalize the tax treatment between employees who receive tax-free employer-paid health coverage and those individuals who must obtain their own. Providing the full tax benefit will help to overcome the high cost of insurance which puts adequate health coverage out of reach of many workers and their families.

4. Examine COBRA continuation benefits.

Hearings were never held on a 1985 law that requires employers to offer former employees and their dependents the opportunity to continue participating in group health plans. Making health insurance more expensive for those employers who are already making their best effort to offer health benefits is leading to less coverage, not more.

An example of the problem

Mr. David Gilbert, Sr., who operates The Rice Planter and Planter's Back Porch in the Grand Strand area of Myrtle Beach, SC, and his employees have been the victims of "COBRA," the well-intentioned 1985 federal law that requires employers to allow former employees and their dependents to buy into the employer's group health plan. Since 1973, Mr. Gilbert has provided hospitalization and major medical and life insurance to his employees. Until mid-1989, Gilbert paid the full premium for individual coverage for his 35 full-time employees.

However, because one former employee, an individual with cancer, took advantage of COBRA continuation coverage, Gilbert 's individual premiums increased 230%. Family premiums increased 220% — all in a 13-month period. Gilbert now pays for only 75% of his employees' premiums.

5. Eliminate state mandates.
There are currently over 800 state mandates that drive up the cost of health insurance, requiring even basic insurance policies to cover such services as acupuncturists, chiropractors and naturopaths. By preempting these mandates and allowing employers to offer a less expensive, no-frills health benefits package, the federal government would allow businesses to provide employees with at least some type of coverage at an earlier point in the business's growth cycle.

6. Make it easier for small businesses to form multi-employer trusts.
The Department of Labor and the Internal Revenue Service should review their rules governing multi-employer trusts, allowing heterogeneous small businesses to pool together, centralize administration and gain a more stable risk rating.

Cost controls, not mandates

Foodservice operators want to provide health insurance for their workers. For employers and employees alike, however, the biggest deterrent to health care coverage is cost. The National Restaurant Association asks Congress to craft incentive-based solutions that will allow businesses to continue to provide health care coverage for employees and remove the barriers that prevent so many of them from doing so.

For more information, please contact the National Restaurant Association Government Affairs Department in Washington, DC, at (202) 331-5900 or (800) 424-5156.

The Foodservice Industry

1991 Sales ■ $248.1 billion
Units ■ 657,000
Employees ■ 8+ million
Foodservice share of the
consumer food dollar ■ 43%

Foodservice - an integral part of our nation's economy

- Foodservice sales will rise 5.2% in 1991.
- Industry sales in 1991 will equal nearly 5% of the U.S. GNP.
- Foodservice receives 43% of the consumer's food dollar, up from 25% in 1950.

Eating and drinking places - mostly small businesses

- 72% of eating and drinking place firms had annual sales less than $500,000 in 1987.
- Three out of four are single-unit operations.
- One out of three are sole proprietorships.
- There are more proprietorships and partnerships among eating and drinking places than in any other retail trade.

Foodservice - a ladder to job opportunity

- Total annual wages and benefits equal $25 billion for restaurants and lunchrooms, and $20 billion for fast food establishments.
- More than 500,000 people will be employed in managerial and administrative occupations at eating and drinking places by 2000.
- In 1989, 12% of the 356,000 food preparation and service supervisors were black and 9% Hispanic.

National Restaurant Association

HEALTH POLICY CORPORATION OF IOWA,
Des Moines, IA, April 26, 1991.

Senator LLOYD BENTSEN, *Chairman,*
Senate Finance Committee,
U.S. Senate,
SD–215 Dirksen Senate Office Building,
Washington, DC.

In re: National Health Care Reform

Dear Senator Bentsen: Thank you for this opportunity to provide comment on national health care reform. HPCI is a coalition of Iowa's leaders working together for an affordable and excellent health system that works for the Iowans. In doing so, we believe it is critical that we develop partnerships and a common vision with the state and Federal Government. With that goal in mind, we offer the following specific suggestions.

Community and System Goal—To protect and improve the mental and physical health of every citizen by: Encouraging a healthy lifestyle; maximizing the value of health services; assuring that all citizens are included in a health plan; defining and ensuring appropriate incentives and accountabilities for consumers, purchasers, health plans, providers and government.

Statement of Principles—Citizens should have a healthy society, where each persons' mental and physical health status maximizes his or her ability to lead a happy and productive life and where:

- Every citizen is part of a health plan that enhances individual well-being, benefits society with improved lifestyle and productivity and allocates resources in a judicious manner for optimal outcomes.
- Choice, diversity and innovation are fostered.
- Consumers have ultimate responsibility for their own physical and mental health status, to the extent that they are able, and are encouraged and supported to live a healthy lifestyle.
- Consumers, purchasers, health plans, health service providers and government work in concert to continuously improve the value of health systems, e.g., continuous quality improvement.
- Consumers and purchasers work in concert to determine the value of health services they are willing and able to purchase; and continuously monitor performance with the objective of improving health service over time.
- Consumers and purchasers hold health plans accountable to continuously improve the value of the service provided.
- Health plans provide an integrated system of health services.
- Health plans and providers of health services work in concert to determine how to efficiently and effectively meet the needs of their customers.
- Judicious use of health resources is promoted through financial and other incentives for consumers, purchasers, health plans and health service providers.
- The value of health services is measured, compared and improved.
- Comparative, specific data and information about health service providers are available to consumers, purchasers, health plans, health service providers and government.
- Citizens have understandable information regarding the risks, expected outcomes and costs of options for dealing with conditions they may have.
- Those that are unable to be fully responsible for their own health receive assistance from government to ensure that an adequate level of health services are available.
- Appropriate levels of services are geographically accessible to all citizens.
- Early and informed decisions are made regarding medically prolonging life.

Blueprint for a New Structure—All groups must work in concert to build this new structure. Each group must have clearly defined roles, responsibilities and incentives within the context of social moras as reflected by laws, regulations and government programs.

- Customers describe *what* value they place on specific health services.
- Health plans and providers determine *how* to provide services that meet the customers' expectations of value.
- Informed consumers have access to a choice of integrated systems of health services.
- Informed consumers and purchasers hold health plans *accountable* for meeting their expectations.

• Health plans hold health service providers *accountable* for the value of the services provided.

Roles and Responsibilities—It is critical that specific and clear roles and responsibilities be defined for each of the five constituency groups: consumers, purchasers, health plans, providers and government.

CONSUMERS ROLES AND RESPONSIBILITIES

• Responsible for their own physical and mental health status (as they are able) emphasizing wellness, positive lifestyle and prevention.
• Responsible for using health systems appropriately, by:
• Becoming better informed about the health systems and their health plan options.
• Participating in decisions affecting their health by asking questions about risks, expected outcomes and costs.
• Participating in the decision on their treatment plan and then follow the agreed upon plan.
• Recognizing the cost of excessive demands for health services.
• Recognizing the limits of what can be done by health professionals and institutions.
• Accepting the fact that there are appropriate limitations to coverage.
• Work with purchasers (often employers) to determine the value of health services they are jointly willing and able to purchase.
• Participate in the financing of the health services they use, as appropriate and within their capacity.
• Work with providers to deal with ethical and judicial issues resulting from improved medical technology and prolonged life. Purchaser Roles and Responsibilities.
• Determine the objectives and priorities for their health benefit plans.
• Share information and assist in providing education for consumers so they can use the system wisely and understand the need for system change and the options for change.
• Work jointly with consumers to identify and articulate needs, preferences and expectations of the value to be received from health expenditures.
• Be accountable to consumers for identifying and monitoring the value provided by various health plans.
• Develop working relationships with health plans to monitor and improve the value of health services provided to customers on a continuous basis.
• Provide information and incentives for consumers to use health services appropriately and to select the most efficient and effective health plan.
• Choose health plan(s) that provide the best value for purchasers and consumers by:

• Meeting purchaser specifications most efficiently and effectively.
• Contracting with efficient, effective and high-quality providers and encouraging the enrollee to use those providers.
• Providing incentives for consumers to use health services appropriately and be conscious of the cost of those services.
• Encouraging consumers to use preventive services and to choose a healthy lifestyle.
• Structuring plans where providers share both the risks and rewards of achieving performance goals.
• Hold health plans accountable for achieving performance goals for both health and administrative services.
• Work with other purchasers and employers to develop suppliers of health programs that can meet their expectations and work to meet the need for administrative simplicity.
• Work with providers to deal with ethical and judicial issues resulting from improved medical technology and prolonged life.

HEALTH PLAN ROLES AND RESPONSIBILITIES

• Develop working relationships with purchasers and providers to facilitate the free flow of information and shared responsibility for improvement of the value provided to and the health of consumers.
• Be an agent for purchasers by representing the purchasers' and consumers' needs and expectations to providers and by obtaining the best value.

• Design flexible products and services to meet wide variations in the needs and expectations of consumers and purchasers, including developing unique and innovative relationships with providers.
• Incorporate research results to improve the value, appropriateness and effectiveness of medical practices for both prevention and treatment.
• Work with providers to manage care through determining and monitoring how much care is appropriate and the most appropriate settings.
• Monitor outcomes and compare the results achieved by different providers and approaches within their plan and with state or national norms.
• Identify providers and consumers who abuse or misuse health systems and take appropriate action.
• Identify the relative value of services provided and take appropriate action.
• Encourage wellness and prevention through educational programs and incentives.
• Review providers's performance before including them in the plan.
• Work with providers to evaluate the appropriateness of state-of-the-art technology, its costs and effectiveness.
• Establish and evaluate arrangements with providers to assure the best value.
• Work with providers to deal with ethical and judicial issues resulting from improved medical technology and prolonged life.
• Identify and apply parameters for treatment, to be used to establish payment for units of service that reflects the value received.
• Negotiate with providers fair and equitable payment for all services.

PROVIDER ROLES AND RESPONSIBILITIES

• Develop guidelines for treatment and practice parameters to be used in the establishment of accepted norms for treatment in coordination with other states, the Federal Government and private groups.
• Establish mechanisms for the application of the guidelines.
• Develop collaborative integrated systems that deliver services which continuously improve the providers' ability to meet consumer needs.
• Provide price, utilization and quality data to consumers, purchasers, health plans and government.
• Identify and efficiently deliver appropriate and effective health services.
• Prospectively establish the price of their services.
• Be accountable for outcomes.
• Be responsible to maintain up-to-date practice standards which improve quality and are cost-effective.
• Continuously improve the value of services provided to their customers.
• Work with purchasers, consumers, health plans and government to deal with the ethical and judicial issues resulting from improved medical technology and prolonged life.
• Establish clinical guidelines and aggressive education programs for health professions and society to address ethical and judicial issues.
• Develop practice parameters for treatment to be used for payment.
• Negotiate fair fees and charges with health plans that reflect value received.
• Participate in peer review to improve quality.
• Participate in quality measurement activities and share the information with health plans, purchasers and consumers.

GOVERNMENT ROLES AND RESPONSIBILITIES

• Protect the public health by setting, monitoring and enforcing health standards.
• Provide for necessary assistance to those unable to assume full responsibility for their own well being.
• Fund and disseminate the results of research that improves both value and quality of consumer health.
• Provide for the timely gathering, compiling and disseminating of valid and reliable data that compares costs, utilization and quality of health services.
• Inform and educate consumers, purchasers, health plans and providers.
• Continuously assess the costs and benefits of administrative/regulatory demands created by government and take appropriate action.
• Create an environment that enables all constituencies to fulfill their roles and responsibilities.
• Government also functions as a purchasers, health plan and provider in some circumstances.

We at HPCI have been working on health care reform in Iowa for some time. In fact, HPCI was formed by Iowa leaders in the public and private sector associated with the *1982 Governor's Commission on Health Care Costs Final Report.* Thus, we have accumulated much knowledge, experience and resources. We offer the following additional relevant information upon request:

- *Healthy Iowans: A Blueprint for an Affordable and Excellent Health System that Works for the People of Iowa,* 1990
- *Healthy Iowans: Public Policy for New Partnerships,* 1991
- *Purchaser's Guide to New Partnerships. Contracts and Accountabilities,* 1991
- *A Guide for Assessing Health Care Needs Developed for Iowa Employers,* 1990
- *Financial Access to Health Care in Iowa. Final Report, April,* 1988
- *The Employed Uninsureds. Final Report, January,* 1989
- *Governor's Commission on Health Care Costs. Final Report*

Thank you for this opportunity to comment on national health care reform.

Sincerely,

Paul M. Pietzsch, *President.*

NFIB

National Federation of
Independent Business

STATEMENT OF

NATIONAL FEDERATION OF INDEPENDENT BUSINESS

SUBJECT: Small Business Access to Affordable Health Care and Health Insurance

BEFORE: Senate Finance Committee

DATE: April 9, 1991

On behalf of the more than 500,000 small business owner members of the National Federation of Independent Business (NFIB), I am pleased to participate in this hearing. NFIB's membership mirrors the national business population in its make-up. This parallel to the general business community and our large membership base are particularly important as it provides validity to the numerous studies the NFIB Foundation and the NFIB have conducted.

Small businesses have always been a dynamic force in the American economy. Millions of Americans own and operate small businesses. Over 19 million Americans report income or losses from business activity and self-employment is the principal job for over 13.8 million of our fellow citizens. Of the 10.5 million jobs created in the past decade, a vast majority were created by small business. Small business employs over half the work force and provides income for millions of families.

To better understand and evaluate the health insurance issue, NFIB has conducted three comprehensive surveys. These surveys, conducted in 1978, 1986 and 1989, reveal the practices, opinions and attitudes of small business owners. Other surveys have been conducted to fill in the gaps. These surveys are unique in the field and are the basis of today's testimony and our "Access for Small Business" strategy.

Suite 700
600 Maryland Ave. S.W.
Washington, DC 20024
(202) 554-9000
FAX (202) 554-0496

The Guardian of
Small Business

Introduction

The number one problem facing small businesses today, and for the past seven years, remains the rising cost of health insurance. It was the number one problem when NFIB surveyed its members in 1983, in 1986, and again in 1990.

This presents you and others in the public policy arena with a two-fold dilemma. The first dilemma is cost as a barrier to businesses seeking to offer health insurance for the first time. The second, and an increasing problem, is rising costs jeopardizing current coverage.(1) Thus the so-called small business problem is actually two problems with one common root -- rising costs -- and that core problem acts as a barrier to access for all small businesses nationwide. Without affordable health insurance and reasonable health care costs, there can be no discussion of increasing the number of covered Americans.

The core problem of rising costs is fueled by two distinct forces, medical inflation and counterproductive government intervention. Both of these must be addressed in order to bring long-term stability to the marketplace and to enable businesses and individuals to purchase quality, but affordable, health care. This does not mean that there is no role for government programs. To the contrary, expanded incentives and reforms in the insurance marketplace and increased competition in health care services will never solve the entire problem. Government programs, such as expanded community health centers, are necessary to fill the gaps and to reach those in the urban areas where the problems are of a different, and greater, magnitude.

The causes of the cost crisis are numerous and are the result of not allowing the marketplace to operate efficiently. These causes can be divided into five generic categories:

1. Medical inflation. The demand for newer and better services is, of course, met with an overwhelming supply of both, but this occurs in a market that does not have the traditional checks and balances fostered by competition and information. Add the increased demands spurred by Medicare, Medicaid, and state mandated coverage, and the result is raging inflation.

2. The cost shift from the federal government and self-insured businesses. The so-called savings achieved in Medicare and Medicaid are not the result of more efficient medical practices, but rather are the result of businesses picking up the remaining portion of the federal government's unpaid bills. Not only is the private sector paying for the care provided to federal program beneficiaries that is not reimbursed, it is the small business community that is shouldering the bulk of that burden. It is the small, non-self-insured business that is unable to negotiate discounts or enter provider networks that are hit the hardest by the cost shift.

3. Imposition of government erected barriers. These barriers include state health insurance mandates; state anti-managed care laws which limit flexibility and cost savings; COBRA, which drives up the cost of insurance for current employees; and ERISA, which distorts that marketplace.

4. An unpredictable and distorted insurance market that rejects the time-honored insurance principle of the law of large numbers and cross subsidization.

5. Usurpation of individual choice and responsibility, coupled with a tax code that discriminates against non-employer-based health insurance purchases and purchases by unincorporated businesses.

State of Small Business and Health Insurance

As mentioned previously, for small business workers and their employees, access to health insurance and quality health care is determined by cost.(2) Cost also explains a recent phenomenon -- the slight decline in the number of small firms offering health insurance as a fringe benefit.(3) Cost prevents new firms from offering health insurance(4) and jeopardizes the continuation of existing health insurance benefits.(5)

The cost of health insurance can be the greatest payroll line-item cost in a small business -- many times exceeding the combined cost of workers compensation and liability insurance.(6) Exacerbating the problem, a majority of small firms pay 100% of the premium cost. These same businesses have little access to managed care or cost-containment measures because of the incessant churning that is occurring in the marketplace. In addition, small firms are unable to obtain the benefits of self-insurance(7) and therefore must comply with expensive state-mandated benefit laws(8), pay state premium taxes, and shoulder a larger portion of the carrier's administrative expenses.(9) Further, churning has resulted in higher tracking costs and brokers commissions.

Small businesses are reaching the peak of the frustration level.(10) This reluctant call for help comes as a result of the clash between values and reality. Small business owners believe that every American has a right to health care.(11) Small business owners also desire to offer health insurance as a fringe benefit out of both a sense of familial obligation (12) and competitive necessity. (13) However, the reality of 20 to 300% premium increases, a low profit margin (14), struggling regional economies, and restricted cash flow impairs the business' ability to purchase health insurance.(15)

Two thirds of small businesses offer health insurance.(16) In general, these firms tend to be more mature, more profitable, and have more full-time employees than their counterparts that do not offer health insurance.

Despite being fairly stable, these small firms experience high initial premiums and higher renewal premiums. Frequently-cited reasons for the high cost of health insurance for small firms include:

- o Insurer fear of adverse selection.
- o Instability of the firm.
- o Lack of expert help in choosing plans.(17)
- o Little negotiating clout.
- o Strict experience rating.
- o Nature of the small business work force:
  - * labor intensive
  - * high percentage of part-time employees(18)
  - * high percentage of older workers
  - * high percentage of very young workers
  - * more remedial workers
  - * high turnover
- o High administrative costs for the carrier.
- o Insufficient experience data.
- o Absence of preferential treatment afforded to larger firms.
- o Imposition of state premium taxes and mandates.

For those not offering health insurance, the following factors have been consistently identified as the most common inherent barriers to offering health insurance:(19)

- o Cost of premiums or past increases too great.
- o Insufficient profits.
- o Insufficient cash flow.
- o Employee turnover too great.
- o Too many employees covered elsewhere -- secondary wage earners.
- o Too many part-time employees.
- o Too many older employees.
- o Employees prefer cash compensation.
- o Too small to receive group "discounts".
- o No suitable cost-containment options available.(20)

However, it is interesting to note that two out of three of those not offering health insurance want to because they believe it is in the firm's best competitive and moral interest to do so but are thwarted from offering coverage because of costs.

The above "inherent" factors, coupled with the currently fractured marketplace, result in limited availability of health insurance for small business.

The Small Business Problem

The major underlying problem for small business is the cost of insurance and medical services. As described above,

some of the insurance costs are directly related to traits which are inherent in a small business. Rising health care costs, on the other hand, result from a non-competitive medical services marketplace. Still other small business costs are the direct result of changes that have occurred in the sale of insurance, changes which have forced carriers to respond in ways adverse to the interests of individual and small business purchasers.

To recap, the characteristics of smaller businesses that most significantly impact premiums, include the potential for adverse selection, the demographics of the small business work force, high turnover resulting in unpredictable participation rates, and a lack of expertise and clout in purchasing plans. Many of these factors drive up the carriers' administrative costs and make the small business community a less profitable marketing target.

Rapidly rising health care costs are driving the entire problem. Without medical cost containment, all mentioned solutions are simply short-term, temporary measures that will have little long-term impact. The medical inflation costs can be tackled through a combination of research, public information, education and enhanced consumerism. Health care providers and their patients must be educated to understand that more does not necessarily equal better, and expensive does not necessarily connote quality. Patients must be encouraged to question providers' fees and practices. Specific cost containment proposals are presented in NFIB's "Access for Small Business" strategy described later.

Increasing health insurance costs are also linked to the destruction of the industry's risk pool, induced by the passage of ERISA, which has forced almost 60% of the business community to self-insure to escape costly state regulation and taxes. The shrinking of the traditional insurance marketplace coupled with the trend toward reliance upon employer-based insurance has lead to new and aggressive underwriting practices for small firms.

Aggressive underwriting artificially raises premiums as insurers seek to protect themselves from all foreseeable, rather than potential, health risks. These practices have also institutionalized "churning," where insurers induce premature and frequent changes from carrier to carrier. This in turn leads to unforeseen adverse consequences. First, the preexisting condition clauses imposed on new customers can leave employees and owners without coverage for critical medical conditions. Second, each time a small business changes carriers in pursuit of lower premiums, it inadvertently raises the cost of the premium by increasing the carrier's administrative costs and by paying brokers' commissions. Third, frequent changes preclude the formation of small business associations or pooling mechanisms. And, fourth, this unstable marketplace means that insurers are unable to apply managed care concepts to the small group, thus leading to higher utilization costs.

All of these factors combine to make the small business marketplace volatile. This instability has resulted in higher premiums and lower coverage than the rest of the business community. This higher percentage of uninsured workers and owners is directly related to the high cost of insurance for small businesses.

The Solution -- "Access for Small Business" strategy

Attached as Appendix #2 is NFIB's broad outline for our "Access for Small Business" strategy. This strategy was explicitly created to accomplish the objective of ensuring that affordable insurance is available to small businesses and, by inference, to individual purchasers. It is essential that the solutions do not rely exclusively on employers and that the reforms promote the purchase of insurance by individuals and the formation of non-employment based purchasing groups.

The "Small Business Access" strategy; however, only brushes upon solutions for the other problems facing our society. A large part of the "health care crisis" remains untouched by the community but must be addressed in order to achieve significant improvement in the health status of all Americans. Health problems stemming from drug abuse, inner city violence, inadequate immunizations, etc. are outside the scope of NFIB's proposal, but should be an integral part of any successful health care reform effort. If they are not, our efforts will be viewed as a failure.

Small business owners desire to change the status quo, but prefer an incremental approach. They believe that current reliance on an employment-based system has worked. Since 1940, the number of people covered by health insurance coverage through their employer has increased from 40% to 84%. They also believe that this success can be built on and that coverage can be increased through a combination of incentives, a return to free market principles, and reforms of current law, that should be supplemented with a new reliance on non-employment-based insurance purchasing. Those changes, by their very nature, are incremental, but taken together represent a persuasive and comprehensive approach to ensure that a significant number of Americans are covered by health insurance.

The basis of the "Access for Small Business" strategy is two fold. The first prong consists of cost containment measures. The second suggests reforms designed to ensure the availability of affordable insurance. Both prongs must be addressed in tandem.

NFIB believes the problems facing small business in the health area are directly related to a dysfunctional market. Part of the NFIB incremental solution is to return competition

to these markets. Simply bringing predictability and competition to the marketplace will significantly drive down the cost of premiums. Further, reforms will help to reduce the cost of insurance packages even further and cost containment will control medical spending.

It is important, however, to understand the small business "definition" of insurance. Insurance is first and foremost a risk transfer mechanism. It is a necessary means by which one is protected from huge financial burdens, not simply a method by which to pay providers. Insurance is also a valuable fringe benefit. It is a means to attract and retain good workers, and it is a way to protect what is in effect the owner's extended family -- his/her employees.

Market Reforms and Incentives (21)

Several ways exist to reduce the impact of disproportionate administrative costs on smaller firms. It has been estimated that a large business receives 95 cents of benefits for every premium dollar. On the other hand, a small business receives only 65 to 75 cents for every dollar spent, thus 25 to 35% of its premiums are used to pay the administrative costs and profits of insurance companies. This administrative burden can be 20 times higher than that borne by a larger company. If the administrative costs alone could be reduced, the savings could be passed along to the small business. We can start that process by reducing the amount of paperwork flowing through the health care system. Streamlining and computerizing insurance and health delivery forms, including Medicare and Medicaid, will save thousands, if not millions of dollars. Further savings may be possible by eliminating the duplicate coverage that occur in home, auto, business and health policies.

* NFIB recommends the standardization of ratings practices. Small groups should be rated and charged premiums on the same basis as a larger business and should have the same predictability in premium increases. Through our surveys, NFIB has found that the inability to predict future premium costs keeps a great many small firms out of the insurance market and puts other firms on an expensive treadmill. NFIB believes that the practice by some aggressive insurers of arbitrary cancellation should be curbed. We also recommend the elimination of durational rating by restricting the ability of companies to lowball the initial premium through preexisting condition clauses.

* NFIB recommends that greater information be available to the consumer. Access to plain English information serves several purposes. First, it induces competition. Second, it aids small business owners (who themselves are the benefits managers and administrators) to be wiser, informed shoppers. Third, it aids in cost containment if the concept is boldly applied. And, finally, it instills accountability in the system and makes "deceptive" or aggressive ratings practices and defensive medicine less likely to occur. Further, NFIB

recommends publishing schedules of allowed or "usual and customary" charges for medical procedures.

* NFIB recommends that COBRA be reformed to reduce its impact on providing health insurance to current employees. Small business owners have expressed a very real concern that COBRA, in its present form and with its proposed expansions, is threatening insurance coverage. Based upon the numerous complaints NFIB has received, it is recommended expansions be opposed and reforms include:

1. Higher administrative fee: Studies indicate that the COBRA beneficiary greatly exceed the cost of the premium plus 2%. In fact, the average cost is in the neighborhood of an additional 51% with many beneficiaries costing the former employer a great deal more. While an increase may make the COBRA premium more expensive, it will go a long way to reducing the impact the COBRA costs have upon current employee's benefits. Not only is the business subsidizing the COBRA beneficiarys' additional costs, so are the current employees' who many times share in the expense of premium increases. The COBRA Reform Coalition has even documented one situation where over 10 current employees and their families lost coverage because of the cost of one COBRA beneficiary. This is not a situation we would like seen repeated.

2. No third party reimbursement: It has come to our attention that many NFIB members receive COBRA premium checks not from the individual beneficiary but rather from the new employer, which many times is a competitor. This situation clearly defeats the transition purpose COBRA was intended to serve. This problem is a direct result of the ability of a former employee to stay with the COBRA plan until he/she decides to participate in the new employers plan, a decision which could be legally postponed until COBRA expires.

3. Shorter windows: The notice and "look back" requirements of COBRA are extremely burdensome on a smaller business. Many times an insurance carrier requires the employer to pay the COBRA premium to an election being made which results in a flow problem. Further, the "look back" provisions encourage adverse selection which have a serious impact on current employee premiums.

* NFIB recommends a level playing field so all employers have the same incentive to provide insurance. This includes the expansion of the tax deduction for the cost of health insurance for self-employed workers to 100%. The full 100%

deduction is a needed and obvious incentive to encourage expanded, voluntary provision of health insurance and would end the current tax code discrimination against the self-employed, partnership, S-corporation, sole proprietorship and farm owners.(22)

* NFIB recommends the establishment of a tax deduction or a tax credit for individuals for the cost of health insurance. This deduction, made available to non-itemizers, would provide an important and necessary subsidy for people to purchase health insurance on their own. A large part of the solution to this crisis is to recognize that individuals bear some responsibility for their own health care.

* NFIB recommends that cafeteria plans and flexible spending accounts be simplified in order to encourage their usage. These plans have several advantages. They allow employees to purchase care with pre tax dollars and permit the employer to have greater control over total benefit costs. Unfortunately, the complexity of the requirements, the "use or lose" and other financing provisions, coupled with the legislative uncertainty surrounding these devices make them unattractive to small businesses.

* The most important reform NFIB recommends is the across the board elimination of state mandates. The preemption of the 800-plus state health insurance mandates and state anti-managed care laws are essential to lowering the cost of health insurance. The state health insurance mandates -- ranging from herbal medicine care to invitro fertilization to chiropractic care to mental health care -- cumulatively can raise the cost of health insurance for small businesses and individuals by more than 30%. They also have a proven impact on increasing utilization and medical inflation.

The elimination of state health insurance mandates would enable "essential care" packages or standardized nationwide policies to be sold. These policies would be designed to be mass marketed, at a lower cost, to cover basic medical and catastrophic needs. NFIB data indicates that a lower cost plan would have great appeal to firms that currently do not offer health insurance coverage and to those that are struggling to make ends meet. Individuals would also be able to purchase this lower cost plan.

It is important, however, that the mandates by eliminated across the board. In order to have the ability to choose and design an insurance package, the mandates must be completely eliminated and not simply eliminated for a federally-determined "minimum benefit" package. This step is not without precedent. Already over 60% of the business community escapes the costly burden of state health mandates and taxes through self-insurance. This proposal simply provides the same treatment accorded larger firms be given to smaller ones.

Cost Containment Reforms

NFIB believes that reforms in other areas will not be successful until medical inflation is conquered at least brought under control. Attainment of significant cost containment must include, but should not be limited to, the following:

1. Consumerism. Patients must have information on provider fees, treatments and quality. Further, patients must share in the cost of those services. We should not fear the ability of patients to select and refuse treatments.

2. Data and guidelines. These include outcomes research, practice protocols, continuing medical education requirements, peer review, and publication of hospital outcomes.

3. Establishment of a uniform claims system for both private payers and the federal government. This is simply an extension of the Paperwork Reduction Act philosophy to the health field.

4. Wellness education and immunizations. The key to controlling future health care expenditures is to promote healthy behaviors and preventative care.

5. Medical malpractice reform. Reforms such as elimination of the collateral source rule, establishment of a uniform statute of limitations, caps on damages, as well as the use of practice guidelines as a defense would not only reduce malpractice premiums and doctors' fees but would curb the expensive practice of defensive medicine.(23)

6. Outreach to troubled populations. Private insurance cannot reach all Americans and cannot solve all of the health problems this country faces. Universal access is not possible without enhancing programs designed to reach these special populations. This can be done by reforming public health programs.

7. Tie a hospital's non-profit tax exempt status to the level of uncompensated care it provides. A very interesting GAO study indicates that many hospitals receive more in tax forgiveness than they provide in charity care. The original purpose of the tax exemption was to compensate a hospital for indignant care.

8. Reform the Medicaid and Medicare programs to reduce the impact these programs have upon the private sector and to ensure that limited funds are effectively spent

for quality care.

Counterproductive mechanisms

Any government policy that mandates small business owners to cover their employees will be accompanied by small business failures(24), changes in employment policies, higher unemployment and higher product costs to consumers(25). It also will mean an increase in the burden placed on public health programs. Small business owners overwhelmingly oppose mandated benefits(26), pay or play programs(27) and national health insurance(28). Beyond the philosophical opposition to mandates, there is the fear of the high uncontrollable costs it would impose. Most small firms cannot absorb the high cost and fluctuations in premiums that a mandated program would impose, nor can they afford to provide extensive benefits to workers who have little attachment to the work force(29). It is important to remember that many times when a firm does not provide health insurance as a fringe benefit or drops coverage, the owner and his or her family also loses coverage.

A pay or play program is opposed because it is a tax on labor. Already 37 to 50 cents of every dollar in compensation goes toward mandated programs such as workers compensation, unemployment insurance, Social Security, etc. This has had a significant impact on the growth in salary compensation. In fact, there has been no real growth in salary compensation for over six years, a fact mainly attributable to the growth in the tax burden borne by employees. Unfortunately, this runs counter to the desire of the employees who would prefer a wage increase to an increase in benefits,(30) putting small business owner/operators in the unenviable position of denying the former to comply with the latter.

Finally, small business workers oppose national health insurance systems. They remember the efficiency of the Post Office, the compassion of the IRS, the demeanor of OSHA inspectors and Pentagon prices. They have come to the conclusion that the private sector, for all of its problems, can deliver a higher quality and more efficient product than the federal government.

For a number of personal and business reasons the overwhelming majority -- almost 90% -- of America's small business owners want to provide health insurance for their employees. Unfortunately, because of run-away medical inflation, rapidly rising health insurance costs, and an inability to absorb either, they cannot provide coverage or are finding it difficult to continue to do so.

Conclusion

NFIB data collected over a decade clearly shows that cost is the main barrier to increased coverage and the primary cause of reduced benefits. The only solution is to stabilize health care and insurance costs. Medical inflation must be

brought under control and the health insurance market must be stabilized. Without both, the crisis will continue to grow.

NFIB has offered a significant numbers of suggestions for reform. There are others, and we continue to study those. The only options we rule out are national health insurance and mandated, employer-provided health insurance. NFIB believes that the current system has worked fairly well and needs to be adjusted, not replaced. We further believe that universal solutions will eventually make the U.S. health care system worse, not better. The best solution is one arrived at incrementally and one that builds upon the principles of the free market and quality affordable care and insurance.

Again, NFIB appreciates the opportunity to share with the Committee the data and conclusions we have accumulated over the course of more than a decade. Future surveys shall be shared with the Committee as the results become available.

HEALTH INSURANCE AND SMALL BUSINESS

The number one problem facing small businesses since 1983 remains the rising cost of health insurance.

The Dilemma: First, cost is a barrier to expanding coverage to the uninsured; second, rising costs threaten current coverage.

The Causes:

A. Medical Inflation

B. Government Intervention

1. Cost shifting from the discounts "given" to the federal government and large businesses;
2. Expensive state health insurance mandates;
3. State anti-managed care laws that limit flexibility and cost savings;
4. COBRA provisions which drive up premium cost for current employees; and
5. ERISA law which distorts the health insurance market place.

The Small Business Situation: Two-thirds of small businesses offer health insurance as a fringe benefit. One-third have no insurance plan, with a majority of those citing cost as the reason for not offering insurance. Two out of three who currently are uninsured indicate that they would offer insurance if it was affordable. Further, 22% of the uninsured are self-employed workers.

* In 1990, almost 90% of small business owners indicated that it was becoming "prohibitively expensive" to provide health insurance to their employees.

The Small Business Problem: Increasing costs, coupled with problems finding affordable insurance.

A. Some costs are inherent to small business, such as:

1. Lack of expertise in designing and choosing plans;
2. High employee turnover;
3. Labor force demographics of the business;
4. The higher probability of adverse selection; and
5. Higher administrative costs -- an estimated 25-35% higher for small businesses.

B. Others costs are related to changes in the marketplace, such as:

1. Splitting and reducing risk pools through the prevalence of self-insurance;

2. Aggressive medical underwriting of small firms;
3. Forced compliance with state mandates and taxes by small, non-self insured businesses;
4. Churning which leads to the inability to apply managed care concepts to a small business; and
5. High medical inflation.

The Solution: Small businesses urge the adoption of an incremental approach to expand employment-based and individual coverage instead of the creation of a new bureaucratic process or program. There is also no political consensus for a universal approach. Incremental changes where consensus is possible can mean successful accomplishment of the goal of expanded coverage.

A. **Cost Containment** -- No long-term success can be achieved without tackling medical inflation and restoring competitive forces to the marketplace. First steps include:

1. Patient involvement in decision making;
2. Incentives for individuals to purchase insurance;
3. Outcomes research, guidelines and peer review; and
4. Publish mortality effectiveness and price data.

B. **Small market reforms** -- Some of the practices of carriers operating in the 250 employees or fewer market must be changed, and the law of large numbers must be reestablished. A beginning is to look to the proposals the industry itself has put forward. Some other reforms include:

1. Preempt, across-the-board, state mandates and anti-managed care laws;
2. Permit the offering of an essential care package which provides affordable basic coverage; and
3. Prohibit aggressive insurer practices that encourage churning, increase administrative costs and force excessive underwriting.

C. **Additional Measures**

1. Enact 100% deductibility for the self-employed.
2. Pursue wellness education and incentives.
3. Undertake children's health initiatives.
4. Enact medical malpractice reform.
5. Reform the public health programs, including expansion of community health programs to address the crisis outside of the small business problem.

END NOTES

(1) A telling illustration of this is the increase in the number of uninsured self-employed business owners from 19% in 1989 to 22% in 1990.

(2) The NFIB Foundation has conducted three comprehensive health surveys: 1978, 1986, and 1990. In addition, in 1983 and 1986, small business owners were asked to rank in order of importance 75 issues from liability insurance to garbage collection to taxes. Health insurance was ranked number one. Surprisingly, health insurance even ranked higher than liability insurance (ranked #2) at a time when the liability insurance crisis was at its peak (1986).

(3) Two-thirds of small businesses offer health insurance. Between the first NFIB study (1978) and the second study (1986), the number of small firms offering health insurance increased by 8 percentage points. Between 1986 and 1990, the percentage of small firms declined by less than 2 percentage points. The decline may be within the range of statistical error or may be the indication of a trend. A 1990 follow-up field survey indicates the latter may be operating. These results were confirmed by the ICF study sponsored by the Small Business Administration.

(4) "New" refers to both established and start-up firms. While two distinct groups, they share at least two common characteristics -- marginality and very limited cash flow. In addition, new firms have no past experience upon which insurance companies can assess the risk.

(5) In 1990, over 89% of small business respondents cited the cost of health insurance as becoming "prohibitively expensive." In 1990, 19.7% of firms surveyed <u>without</u> health insurance indicated that health insurance was offered at some time in the past.

(6) Between 1987 and 1990, small business health insurance premiums rose from an average of $1,942 to an estimated $3,192 [Foster & Higgins data].

(7) Over 50% of the business community self insures, and that number has been rapidly increasing since ERISA's passage in the 1970s. Most firms that self insure tend to be large and profitable. Less than 49% of small firms are

able to self-insure. Self-insurance provides at least four benefits: 1) compliance with state mandates is not required, 2) no state premium taxes are assessed, 3) administrative costs are lower, and 4) the company has complete flexibility to design the health benefit plan.

(8) There are over 700 state-mandated health insurance benefits requiring coverage for everything from chiropractic care to mental health care to in vitro fertilization to herbal medicine treatments. State health insurance mandates drive up the cost of health insurance for small firms between 20 to 30%. Larger businesses that can self-insure under ERISA are able to avoid these mandates and design their health plans according to their employees' needs, not as defined by the state government. In addition, state health insurance mandates have been shown to increase medical care inflation by creating an artificial demand for services. The Center for Policy Analysis (Dallas, Texas) estimates that 25% of the uninsured, both businesses and individuals, are the result of the higher costs created by state health insurance mandates.

(9) SBA estimates that large firms receive 95¢ of benefits for every dollar in premiums spent, whereas smaller firms receive 60-75¢ of benefits for every dollar spent.

(10) Sixty-one percent of the respondents in 1989 called for government help in reducing the cost of health care and health insurance. Small businesses also supported the imposition of doctor fee structures in Medicare. However, the majority of small firms oppose national health insurance and an overwhelming majority oppose mandates, strongly believing there are market-oriented "fixes".

(11) Sixty-nine percent either agreed or strongly agreed that every American has the right to basic health care regardless of ability to pay, but they also believe that individuals have the primary responsibility.

(12) Health insurance is the second most frequently offered benefits in a small firm. The first benefit offered is paid vacation time.

(13) In today's shrinking labor market, small firms are intensely competing with both large and small businesses for qualified, skilled employees. A less generous fringe benefit package is a competitive disadvantage which neither attracts nor retains good employees.

(14) The median small businesses owner takes out of his/her business less than the median wage and salary worker. About 40% of the 1989 study respondents took out of their business less than $30,000 last year.

(15) Small firms are price sensitive. Of those firms not offering health insurance, 28% said they would offer insurance if premium costs were lowered at least 20%.

(16) To date, the employee-provided health insurance system has been successful. The number of Americans covered by employment-based insurance has risen from 40% in the 1940s to over 80% in 1988.

(17) Small businesses typically engage in "one-stop shopping. One independent insurance agent is used to provide all of the business' insurance needs. In addition, there is limited expertise in the small business with respect to benefit design and negotiation. The owner is typically the benefits manager, payroll administer, etc. The average small business owner spends 8 to 10 hours a week on paperwork alone.

(18) Small business owners view full-time employees (defined as working over 25 hours a week) as distinct from part-time employees. The limited connection to the workplace and the part-timers' preference for cash compensation or flex-time explain a difference between the benefits offered the two types of employees. This difference has been institutionalized by the insurance industry, which charges higher premiums for part-timers or refuses to cover such employees.

(19) Less than one percent of those <u>not</u> offering health insurance stated that under no condition would health insurance be offered.

(20) Less than 4% use HMOs or self insure.

(21) NFIB currently has a follow-up survey in the field seeking to specifically identify insurance reforms beyond those mention in this section. The small businesses owners will be asked for their opinions on items such as guaranteed issue, community rating, tax preferences and risk pools.)

(22) The implications of such an expansion are immense -- over 21% of self-employed workers are uninsured and 30% of these businesses employ one to four people. If the full deduction were restored, possibly one quarter to one half

of the working uninsured and their dependents could be helped. A full deduction provides a powerful financial incentive by reducing the cost of health insurance for perhaps the most expensive-to-cover portion of the business community.

(23) The threat of malpractice claims is estimated to add $4 billion to the cost of health care each year. It is also estimated that defensive action on the part of doctors costs $100,000 per year per physician. (Source: Small Business Administration, 1991)

(24) 12-26% surveyed indicated they would go out of business if the cost of the package was $50.00 to $150.00 per employee per month. (Small Business and Health Survey, NFIB Foundation)

(25) Over 25-49% said they would change employment practices. 61% said they would raise prices if possible, 25% would eliminate part time jobs, and 31% would reduce other benefits. (Small Business and Health Survey, NFIB Foundation)

(26) NFIB MANDATE vote: 89% oppose mandated health benefits (4% undecided, 7% favor). Full membership polled.

(27) NFIB MANDATE vote: 94% oppose "pay or play" schemes (2% undecided, 4% favor). Full membership polled.

(28) MANDATE vote: 78% oppose a national health insurance program (6% undecided, 16% favor). Full membership polled.

(29) Small Business and Health Care, 1990 NFIB Foundation

(30) Small Business and Health Care, 1990 NFIB Foundation

Further information may be obtained in the 1989/1990 "Small Business and Health Care" survey by the NFIB Foundation (Drs. Hall and Kuder). The survey was drawn on a random sample of 16,614 small business owners. Over 5,300 useable surveys were returned for a 29 percent response rate. A comparison of the estimated small employer universe and the survey respondents generally indicate that they are similar in size, industrial distribution, and geography (with a very slight western states bias).

APPENDIX 2
Access for Small Business Strategy

OBJECTIVE: To improve access to health care through affordable health insurance and cost-effective quality medical care.

I. Renewal of Federal Government Obligations

- A. Medicaid reforms
- B. Medicare reforms
- C. 100% deduction for the self-employed, sole proprietorship, partnership, and S-Corporation business owners (HR 784)

II. Removal of Government Barriers

- A. Pre-emption of state health insurance mandates
- B. Pre-emption of state managed care restrictions
- C. Simplification of cafeteria plans and METs
- D. Reinstatement of the individual line-item deduction for health insurance premiums.
- E. COBRA reform

III. Cost containment mechanisms

- A. Consumer information
- B. Outcomes research
- C. Physician practices guidelines
- D. Wellness education/preventive care promotion
- E. Medical malpractice reforms
- F. Living wills
- G. Coinsurance
- H. Hospital outcomes data

IV. Insurance Industry Preforms

- A. Return to the "law of large numbers"
- B. Underwriting reforms

V. Unacceptable Mechanisms

- A. Mandated benefits
- B. "Pay or Play" schemes
- C. Triggered mandates
- D. National health insurance

SMALL BUSINESS
LEGISLATIVE
COUNCIL

April 25, 1991

The Honorable Lloyd Bentsen, Chairman
Committee on Finance
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

On behalf of the Small Business Legislative Council (SBLC), I wish to submit these comments for the record of the Committee's recent hearings on the subject of the health care crisis in America. As you know, the SBLC is a permanent, independent coalition of over one hundred trade and professional associations that share a common commitment to the future of small business. Our members represent the interests of small businesses in such diverse economic sectors as manufacturing, retailing, distribution, professional and technical services, construction, transportation, and agriculture. A list of our members is enclosed with this statement.

I believe I can say with utmost certainty there is virtual unanimity among small businesses that the number one problem facing small business today is out-of-control health care costs.

Like most groups with an interest in the problem and possible solutions, we have conducted numerous polls and surveys of our membership. At the end of last year, we conducted a survey of 1,000 small firms in Western Cook County, Illinois. This survey was conducted with funds provided by the Department of Commerce and Community Affairs for the State of Illinois. It is only a pilot study for what we hope will be a survey and project including the entire State of Illinois. The principal purpose of the pilot survey was to test the survey methodology, survey instrument, and survey procedures. The pilot project included a mail survey, focus groups, and one-on-one interviews of small business owners in the survey area. We are not presenting this pilot study as a scientific analysis, but we do believe the pilot does provide some useful and valid insights. The trends revealed by the survey are of significant interest to SBLC because they correlate with some developments we believe are taking place within the small business community, which we had previously identified through anecdotal evidence.

The first step in the process of solving our health care crisis in America must be for all of us to identify and agree on what are, in fact, the problems of the current system. For small business, that discussion could begin and end with health care costs. While there has been much discussion about the need for universal access to health care, a concern which we share, we believe lack of access is merely the tip of the iceberg of a more fundamental problem. We greatly fear that the 30-plus million Americans without health care coverage will become 50 or more million. The reason is simple. Health care costs are escalating without rhyme or reason, and small business will soon be forced to discontinue this benefit.

We have conducted several surveys over the years, as have our colleagues at the National Federation of Independent Business, National Small Business United, National Association of Wholesaler-Distributors, and the Chamber of Commerce. While one can quibble about the exact numbers, it is very clear

that premiums have been increasing every year at significant rates of 30 to 70 percent. We believe the current average cost of insurance is now in excess of $3,000 per year per employee.

In our Illinois study, over the past four years, health insurance costs for the firms in the sample increased by an average of 101 percent, far outpacing the rate of increasing other operating costs. Over the past 18 months, the average increase was 38.6 percent. I might note that 80 percent of the respondents have been in business five or more years, and employ, on average, 20 full-time and seven part-time workers.

In macroeconomic terms, the unending, upward spiral of health care costs has several ramifications. In a competitive world, especially when the competition is global in scope and labor costs are far lower in some countries than in the United States, minimization of costs, including labor costs, is imperative for the employer. If it is possible to pass these additional costs to consumers through higher prices, the employer will do so. Higher prices exacerbate inflation and reduce the quantity demanded by consumers, so that less output will be produced and sold. Thus, even if the employer can pass all the additional costs to consumers, profits will be lower because less will be sold; employment will be lower because less will be produced; there is less incentive to expand operations so that economic growth will be slowed; slower economic growth reduces the number of job opportunities and the rate of growth in living standards; and, since profits provide the resources for research and development, innovation will be slowed.

More typically, some of the labor cost increases will have to be absorbed by the employer, which lowers profits. In such cases, the employer will have to decide whether it is profitable to continue to operate the business at all, or to escape the unfriendly cost environment by closing domestic operations and moving abroad. During the 1980s, many high-labor-cost jobs, particularly in manufacturing, were lost by Americans as employers turned to workers abroad in nations such as Mexico, the Pacific Rim countries, and countries in the Caribbean. Rising health care costs, and certainly concepts such as Federally mandated health insurance, would accelerate this process; jobs would be lost; the balance of payment problems would become more severe; and, economic growth would be slowed. Again, lower profits also would lead to less innovation, for there would be fewer financial resources to support research on and development of new products and processes.

Current technological trends are making foreign labor markets increasingly attractive, even for the service industries which so far have largely been immune to job losses. For example, rapid improvements in telecommunications, which have improved the quality of voice and data transmissions and markedly lowered the costs of international communication, now make it possible for low-wage workers in countries, such as Ireland, to process insurance claims, do word processing, and accomplish many other tasks now done by "homeworkers" in the United States. Satellite dishes, high-capacity fiber optic cables, and computers will soon make homework of service tasks a global phenomenon.

Moving operations abroad is a drastic step for any employer and, for most small firms, is simply not an option. The first, and perhaps only, reaction would be to attempt to minimize the impact in other ways. The most direct approach would be to try to reduce labor costs by reducing other forms of employee compensation, such as pay rates and other fringe benefits that are not regulated by the government. Research on the economic effects of the minimum wage, a form of mandated benefit, has shown that increases in the minimum wage have resulted in the reduction of other forms of compensation.

The second option is to identify any means available, within the control of the business, to stem the rising tide of health care costs. Forty-four percent of the respondents in our Illinois study told us they were forced to decrease benefits. A majority of the respondents also indicated that a variety of cost containment provisions were incorporated into their insurance packages as cost control measures, e.g., second opinion for surgery (66 percent), out-patient surgery incentive (59 percent), a pre-admission testing incentive (60 percent), and pre-certification of hospital stays

(59 percent). Co-payment options are also common; 67 percent of the respondents reported a co-payment of 80/20. Most telling, nearly half the respondents "shopped" for health insurance during the past 18 months, a phenomena that creates additional problems in the insurance market. Most employers have had those painful meetings with employees when the employer must inform the employees of the changes he or she must make in order to continue to provide coverage. I can assure you no employer relishes the thought of holding such a meeting.

We recognize that for the 30 plus million without health care insurance access to coverage is their primary issue. However, mandating coverage or establishing a national health insurance system does nothing for the 185 million individuals already covered by private insurance, because such proposals fail to provide any mechanism for controlling costs.

While SBLC is making every effort to focus on positive solutions to solving the health care cost problem, let me expand for a moment on why a mandated benefit is not a solution. The "one size fits all" orientation of any mandated benefit ignores totally the unique circumstances of both individual firms and individual employees. Technology and the demographic composition of the work force have been changing rapidly and these changes have brought new problems into the world of work. However, for small business to respond effectively to change, there must be flexibility, not rigidity. Mandates represent rigidity and inflexibility. Employers do not benefit from workers with low morale and high turnover; they have no alternative but to be sensitive to changing conditions and to adapt to them. The trend in recent years has been toward "cafeteria" fringe benefit plans which permit individual employees to choose for themselves the combination of fringe benefits which satisfy best their needs and circumstances. Each employee is given a specific sum which may be allocated as desired among a wide choice of fringe benefit alternatives. Under cafeteria plans, the costs to the employer are known in advance and controlled, while the benefit package is tailored by the individual employee to best suit his or her needs. Both the employer and the employee are better off under a program which emphasizes choice. No one could possibly be more informed about the unique circumstances and needs of each employee better than the individual employee. Mandated benefits are the antithesis of cafeteria plans and allow "third parties" to impose their ideas about what is best for employees through regulations.

The macroeconomic effects of mandated rigidities in the labor market are clearly illustrated by a comparison of the highly regulated labor markets of Western Europe with the less regulated U.S. markets. There is abundant evidence the U.S. labor market far outperforms the labor markets of Western Europe by a wide margin. Between 1975 and 1985, 26 million *net* new jobs were created in the United States; during the same period, only 2 million net new jobs were created in Western Europe. According to Kitscher and Sorrentino in Employment and Unemployment Patterns in the U.S. and Europe, 1973-1987: "One inescapable fact that remains after all the demographic and industrial analyses are finished: There are many millions more Americans holding jobs today than there were 15 years ago, but only a few million more Europeans have jobs." Not only did the American economy expand to accommodate millions of new "baby boom" workers, but it also provided employment for tens of millions of female workers who chose to participate in the labor force. Moreover, these new jobs were better than those lost, for "the low-earnings category has declined over time; there has been no proliferation of workers with low earnings. And the share with high earnings has gone up," as Marvin Foster observed in The Changing Quality of American Jobs. The reason the U.S. labor market has been so dramatically superior to those in Western Europe is that adjustment to economic changes is facilitated by market flexibility and is retarded by market rigidities:

> There is consensus that labor rigidity is at least partly responsible for the lack of growth in European employment. Even those sympathetic to labor and labor unions concede that labor flexibility is related in one way or another to employment levels.

> The Organization for Economic Cooperation and Development (OECD) Dahrendorf Commission — which included Douglas Fraser, former president of the United Auto Workers — acknowledged the relationship. In addition, the May 1987 communique from the ministerial meeting of the Council of the OECD cited the need for "more flexible labor markets" to "facilitate access to the new jobs emerging as structural and technical change accelerates." The 1987 *OECD Employment Outlook* summarized: "High unemployment presents many challenges. Perhaps the most important is the achievement of the rate of job creation necessary to move toward fuller employment and a more active society." (David R. Jones, European/American Employment Issues).

The rigidities in European labor markets which has inhibited job creation are not accidental; rather, they were caused by government interference in the employment relationship through mandating fringe benefits. Most of the net new jobs in the American economy were created by small firms, not by industrial giants, and mandated benefits discourage the formation of new firms and, thus, the creation of new jobs. Mandated benefits, which have contributed to rigid labor markets in Europe, have resulted in economic stagnation.

Nor is mandating demand a substitute for cost control and stabilization. We are confident that, in addition to ensuring the crisis will not get worse, controlling costs is the first step to providing universal access. If you want to significantly improve the access at the margins, control costs and the number of people covered will increase.

We make that statement because we believe the sands are shifting within the small business sector. In our Illinois study, over 90 percent of the small businesses responding indicated they believe health insurance coverage is a fundamental right for all Americans. More than half of the respondents clearly indicated the employer should indeed be responsible for coverage. There is a quantum leap, however, between undertaking a voluntary responsibility and absorbing a mandatory requirement. The respondents indicated cost is the major obstacle to undertaking that responsibility. We are convinced most small business owners will voluntarily undertake coverage and, in fact, we would suggest the numbers of small businesses providing coverage is already higher than commonly reported. We believe it is already is as high as 85 percent.

The focus for our efforts should be to assist the important contributors to the economy and job creation — the small business with 20 to 100 employees. These are the firms on the edge. They provide coverage now, have been in business for more than five years, but they can no longer continue to provide the benefit. If we can control and stabilize costs so they may continue to provide health insurance coverage, we are confident we will have found the solution to the overall health care problem in our society.

What can be done? We have several thoughts. First, we can initiate insurance market reforms. There are problems in the small case market, particularly with rating practices and policies such as pre-existing condition exclusions. As you know, at one time, "community rating" was the standard for private group health insurance. For a variety of reasons, "experience rating" and "risk segmentation" became the dominant insurance industry practices. The result was destabilization of the small case market. In effect, small business lost the advantages of economies of scale in diffusing risk. Reforms, such as guaranteeing small business the right to buy insurance; assuring continuation of insurance even if employees become unhealthy or change employers, or if employers change insurers; and, placing some limits on both initial and renewal rates, would help stabilize the insurance market. In the end, these initiatives will not lower costs; in fact, moving back to community rating may raise costs slightly for those companies fortunate enough to have healthy employees and, as a result, fall below the average line based on experience ratings. But insurance market reform will provide stability and, in effect, isolate health care costs as the remaining outstanding problem. We might note many of these insurance market reforms were endorsed by the Pepper Commission. We were also pleased to note that Department of Health and Human Services Secretary Louis Sullivan

has expressed interest in insurance market reforms. His recent speech on the subject provides excellent insights on how these insurance market problems evolved.

Second, we can eliminate the proliferation of state-imposed mandates. State legislators have forced insurance companies to increase the number of specific diseases and health care services covered by their basic policies. In 1970, there were only 30 mandated health insurance benefits in the U.S., but by 1988, that number had increased to 686. Thirty-seven states require health insurance coverage for chiropractic services, three states mandate coverage for acupuncture, and two states require coverage for naturopaths, "physicians" who specialize in prescribing herbs. Insurance companies must dramatically increase the premiums charged to customers to offset the costs of increased benefits mandated by the government. It is difficult today to purchase a basic health insurance policy at low rates because of state government intervention in the market. We do believe we can agree on a basic benefit package which can become the universal standard.

Third, we can adopt some measures which will ultimately stabilize the cost of health care in the long term. For example, we need to conduct more outcomes assessment research and work with practice guidelines for the medical profession. Certainly, medical malpractice is a serious problem and we simply must reverse the prevailing litigious nature of our society. Further, we are convinced that product liability concerns are slowing the progress of health care because manufacturers are unable to take the risks of bringing new technologies to the market.

All of these measures will help hold costs down in the long run. But, the crisis is upon us now. In this regard, I return to our Illinois study. The mindset of the small business owner has changed. For four years we at SBLC struck a single note — no mandates and no national health insurance. While small business remains unalterably opposed to those approaches for the reasons I indicated earlier, there is emerging evidence small business is prepared to accept some government participation to stabilize and control costs.

We are not so naive as to believe "free" enterprise is completely free. We are long and ardent proponents of strong antitrust laws. We understand too well that a restrained government hand is necessary to protect and encourage competition. So this would not be the first time we would suggest some limited government participation in establishing the playing field.

The truth is, we do not see true competition in the provider community. Indeed, there is competition for the best contracts and business, but it is not true competition. Given the unique role of health care in our society, reflected in the comments of the small business owners in our Illinois study that health care is rapidly becoming a fundamental right, it may be time to revamp our thinking on how the price of health care is established.

One of the frequently discussed options of controlling health care cost is "managed care." The concept has significant merit. It is a marketplace approach, and it addresses not only cost but quality. We are concerned, however, about whether we can implement managed care on a nationwide level. Managed care, without universal acceptance, creates cost-shifting. Frankly, at the present time, that shift is from large firms to small firms.

An "all-payers" system that results in a universal negotiated rate has some merit as well. One of its significant strong points is also its weakness. Individual small businesses will never have the clout or information to negotiate rates. Experience would suggest that a local negotiating component would be necessary, and we are not sure small business owners would provide the participation necessary to make it work.

There are other cost control ideas and we do not feel prepared to comment upon them, but the central point to be made is we are prepared to discuss some sort of government participation in price setting of health care services. While we are loath to advocate regulation of any business, and health care

services are just that — businesses — we see no hope on the horizon unless we can stabilize and control health care costs. We know this will not be a popular view in the health care community, but it is the reality.

We do know in some quarters, there is discussion of providing small business with a tax credit if their premium costs exceed a certain percentage in a year as a cost control mechanism. The logic of the credit is that if small business is concerned about costs, this eliminates their concern. We are not seeking a tax credit. Frankly, we see no merit in extending small business a lifeline when the boat is sinking. We say solve the underlying problem of uncontrolled costs.

Let's not kid ourselves. Under the current budget agreement, such a credit could not survive the pay-as-you-go requirement but, more significantly, who will pay for this credit? The answer is, the taxpayer. But who bears the burden of our tax system? It is small business owners through their businesses and as middle income taxpayers. And, as costs rise and more small firms avail themselves of the credit, what happens? Taxes increase. A tax credit to cover costs is nothing more than a band-aid.

As we know, the health care delivery system is a complex mechanism. Until you have dealt with it from the perspective a small business owner, it is hard to appreciate how confusing the current system is. In Washington, we have a tendency to assume draconian actions are necessary. One fact that came out of our Illinois study is that most small business do not know what health care insurance options are available to them, nor are they certain who can provide them with reliable information. These owners find themselves struggling with comparing apples with oranges between different insurance and health care programs. Therefore, the first step in enhancing access and controlling cost may be to provide better, consistent information on health care insurance options. It is a simple step, but it can yield results.

We were surprised to learn how few Illinois small business owners knew that the state of Illinois had enacted the Illinois Comprehensive Health Insurance plan for state residents who could not obtain private insurance. While 93 percent of the respondents agreed with the statement "a state government-sponsored medical high risk pool is a good idea," less than 10 percent were aware the state of Illinois had enacted such legislation in 1989. Employers in the Illinois study indicated they need more information about rate setting, plan coverage, cost comparisons, regulations, and cost containment.

Accountability is essential to cost control and, to borrow a phrase, it must begin at home. As health care consumers, we are all guilty of one thing — when a member of our family needs health care, we want the best money can buy. It's easier to say than to put into practice, but we simply must force the individual to participate in the health care process. At a minimum, co-insurance requirements and deductibles do encourage the individual to look more closely at what services are being provided. The component, of what is loosely called managed care, that imposes such discipline on employees is a worthwhile endeavor. Likewise, as everyone, we have watched with interest Oregon's effort to prioritize health care services. To a degree, this imposes some accountability at the community level.

Before closing, I wish to note two other matters. We do support permitting sole proprietors, partners, and S Corporation shareholders to fully deduct their own health care costs. We believe it should be done as a matter of fairness and equity. We support the legislation, S. 139, introduced and co-sponsored by several members of the Committee on Finance. Likewise, we do need to recognize the difficulties confronting new businesses. It simply is impossible to expect them to undertake significant costs. They need to be treated as a unique subset of small business.

In summary, the real health care crisis in America may be yet to come. That crisis could be the collapse of a system burdened by out of control costs that can no longer be economically supported. Our challenge then, is to act now and try to avert such a crisis and ensure Americans continue to have the best health care possible. We look forward to working with the committee to meet this challenge.

Sincerely,

Phillip Chisholm

Phillip Chisholm
Chairman of the Board

Members of the Small Business Legislative Council

Air Conditioning Contractors of America
Alliance for Affordable Health Care
Alliance of Independent Store Owners and Professionals
American Animal Hospital Association
American Association of Nurserymen
American Bus Association
American Consulting Engineers Council
American Council of Independent Laboratories
American Dental Trade Association
American Floorcovering Association
American Institute of Architects
American Machine Tool Distributors Association
American Meat Institute
American Road & Transportation Builders Association
American Society of Travel Agents, Inc.
American Sod Producers Association
American Subcontractors Association
American Textile Machinery Association
American Trucking Associations, Inc.
American Warehousemen's Association
Architectural Precast Association
Associated Builders & Contractors
Associated Equipment Distributors
Associated Landscape Contractors of America
Association of Small Business Development Centers
Association of the Wall and Ceiling Industries-International
Automotive Service Association
Automotive Warehouse Distributors Association
Bowling Proprietors Association of America
Building Service Contractors Association International
Business Advertising Council
C-PORT
Christian Booksellers Association
Council of Fleet Specialists
Electronics Representatives Association
Florists' Transworld Delivery Association
Helicopter Association International
Independent Bakers Association
Independent Bankers Association of America
Independent Medical Distributors Association
Independent Sewing Machine Dealers Association
International Association of Refrigerated Warehouses
International Bottled Water Association
International Communications Industries Association
International Formalwear Association
International Franchise Association
Latin American Management Association
Machinery Dealers National Association
Manufacturers Agents National Association
Manufacturers Representatives of America, Inc.
Mechanical Contractors Association of America, Inc.
Menswear Retailers of America
NMTBA-The Association for Manufacturing Technology
National Association for the Self-Employed
National Association of Brick Distributors
National Association of Catalog Showroom Merchandisers
National Association of Chemical Distributors
National Association of Development Companies
National Association of Home Builders
National Association of Investment Companies
National Association of Passenger Vessel Owners
National Association of Personnel Consultants
National Association of Plumbing-Heating-Cooling Contractors
National Association of Realtors®
National Association of Retail Druggists
National Association of Small Business Investment Companies
National Association of the Remodeling Industry
National Association of Truck Stop Operators
National Campground Owners Association
National Candy Wholesalers Association
National Chimney Sweep Guild
National Coffee Service Association
National Council for Industrial Innovation
National Electrical Contractors Association
National Electrical Manufacturers Representatives Association
National Fastener Distributors Association
National Food Brokers Association
National Grocers Association
National Independent Dairy-Foods Association
National Knitwear & Sportswear Association
National Limousine Association
National Lumber & Building Material Dealers Association
National Moving and Storage Association
National Office Products Association
National Ornamental & Miscellaneous Metals Association
National Paperbox & Packaging Association
National Parking Association
National Precast Concrete Association
National Shoe Retailers Association
National Society of Public Accountants
National Tire Dealers & Retreaders Association
National Tooling and Machining Association
National Tour Association
National Venture Capital Association
Opticians Association of America
Organization for the Protection and Advancement of Small Telephone Companies
Petroleum Marketers Association of America
Printing Industries of America, Inc.
Professional Plant Growers Association
Retail Bakers of America
SMC/Pennsylvania Small Business
Small Business Council of America, Inc.
Society of American Florists
Specialty Advertising Association International
United Bus Owners of America

Statement of the Small Business Service Bureau, Inc.

Chairman Bentsen and Members of the Committee: Thank you for the opportunity to present our views regarding rising health care costs and the lack of access to health insurance. My name is Francis R. Carroll. I am the President and Founder of the Small Business Service Bureau, Inc. (SBSB). SBSB is a national membership organization representing over 35,000 small businesses. SBSB provides legislative advocacy, management assistance and group benefits and services to small companies employing fewer than ten (10) people. One of the most vital services SBSB offers to small businesses is access to group health insurance through Blue Cross and Blue Shield and HMOs.

The affordability and accessibility of health insurance for the small business population has rightly become the focus of state and national attention. Fundamental reform in the small group market is key to resolving the larger problem of the uninsured and underinsured in the small business population. In this regard, SBSB supports the intent of Senator Durenberger's legislation, S. 700, the "American Health Security Act of 1991."

In fact, many proposals for reforming the small group health insurance market have common components which SBSB supports.

1. Prohibiting medical underwriting and denial of coverage to individuals or groups because of actual or anticipated health conditions and claims experience,
2. guaranteeing renewability,
3. limiting pre-existing condition exclusions and waiting periods,
4. prohibiting experience and durational rating,
5. making health insurance programs available without state mandated benefits, at least to previously uninsured small companies.

ACCESS

Accessibility to health insurance is a major concern for small businesses. The underwriting and rating practices for many insurers have become increasingly restrictive for small companies. Small firms often find a commercial health insurer will not cover them if they are sick, have an average age over 40 or are in an occupation that has been blacklisted for coverage. Commercial insurers do not want to insure those who need insurance most.

Commercial insurers can and do refuse to sell insurance contracts if for any reason they do not want to accept the employer's group. They can cancel contracts unilaterally. They can and do selectively deny or restrict coverage for specific employees or dependents, if for example, there is a pre-existing medical condition. They can and do charge prohibitive risk premiums. In addition, insurers often "lowball" the premiums offered to an employer in the first year to win business, and once the account is signed, raise the premiums abruptly by 20, 30, 40 percent or more. Commercial insurers market carefully to attract primarily lower-risk groups. Writing only low-risk business is known as "cream skimming" or "cherry-picking."

These practices foster enormous instability and turnover among small employers who attempt to provide health benefits. If a small business person is hypertensive or overweight, a diabetic, or has a back problem, it is unlikely (s)he will have any commercial health insurance alternatives available to him/her. If (s)he works for a restaurant, health club, florist, retail liquor store, or a gas station (s)he may also be denied coverage.

A health insurer usually accepts all the employees of a large firm for coverage. New employees of a small company are often required to fill out an extensive medical questionnaire to determine their health status and that of any dependents. Those in poor health are denied coverage, or have coverage issued without waiver for the pre-existing condition.

In a small company, one employee in poor health who utilizes health services can jeopardize the coverage of the entire company's group. A claim can result in the insurer cancelling the coverage for the whole company leaving employer and employees uninsured. The company has little or no redress in these situations.

Prohibiting carriers from "cherry-picking" the best risk will diminish the effects of adverse selection on those plans which have not engaged in denying or limiting coverage and access to care, such as many Blue Cross and Blue Shield and HMO programs. A level playing field in the small group health insurance market is a positive step to assist small business in obtaining affordable insurance. SBSB supports prohibiting medical underwriting by all carriers in the small group market, as well as the development of rating structures which spread risks more equitably.

AFFORDABILITY

Many small businesses would like to offer their employees health coverage but cannot afford to do so. Currently, small businesses and self-employed people cannot take a tax credit for the purchase of health insurance for themselves and their employees. Oregon has proposed a five year tax credit of 50 percent of the employer contribution for small companies that have not previously offered health benefits. New York has a proposal allowing for a tax credit against the franchise tax.

At present, large corporations deduct from their Federal taxes 100 percent of their contribution to their employee's health insurance premiums. However, unincorporated small businesses can deduct only 25 percent, and that deduction expires next year. SBSB encourages the Congress to increase the deductibility for small companies to 100 percent, as it is for larger firms.

MANDATES

Currently, up to 18 percent of the total monthly health insurance premiums can be attributed to state mandated benefits. A recent study showed that 16 percent of uninsured small businesses would purchase health insurance for their employees and dependents if there were no such mandates that drive up costs. It is estimated state mandates raise premium costs 20 to 30 percent. There are currently several states which have attempted to reform the small group market. Florida, Illinois, Kentucky1 Missouri, Rhode Island, Virginia and Washington all have passed laws allowing health insurance providers to offer mandate-free policies to small companies previously unable to offer health insurance due to prohibitive costs. In addition, Ohio, Massachusetts and New York are also considering such legislation.

RATING

Premium determination varies among all small group reform proposals. SBSB supports implementation of rating formulas which broadly spread the risk and do not discriminate against small companies because of health care experience, the type of business they represent, or the specific individual age or sex of employees. Community based rating with limits on annual rate increases is a fair and equitable method for promoting affordability of health insurance for a wide range of small companies.

NATIONAL HEALTH

Members of this Congress as well as many state legislatures have proposed universal health insurance programs in an attempt to improve access to health care for all Americans. While this is a lofty and commendable goal, the methods often suggested will hurt one of the populations it seeks to assist, the small business community. Generally, the programs increase existing health insurance premiums for those small businesses that presently can afford to offer health benefits, threatening to push them into the ranks of the uninsured because of unaffordable price.

Small businesses would bear the bulk of new state and local taxes required to implement and maintain these national health programs, in addition to the premium surcharges mandated under the proposals. Not only must small business owners pay higher premiums and more taxes, but their freedom to design employee benefit packages tailored to both their company's financial needs and the needs of their employees is severely restricted. Various state proposals recommend the state governmental authority establish both the benefit level and employer contribution lever. If the employer does not comply with either requirement, (s)he must pay a per employee fee to the state. Should the employer be unable to pay this fee, they must pay a penalty for non-compliance in addition to the fee. This is not sound policy.

CONCLUSION

SBSB supports reforms in the private health insurance market which will improve the affordability and accessibility of coverage for small businesses. We recognize the terrible financial burden and devastation an illness can have on a family with no health insurance. We support reasonable approaches to solving this problem. However, we do not support balancing the needs of the uninsured on the backs of the small business community. The private and public sectors need to work together to keep the country's small businesses operational by promoting access to affordable health insurance for themselves, their dependents and employees.

Nationally recognized expert on economics, Dr. David Birch, indicated that companies with fewer than 20 employees created 88 percent of new jobs between the

last recessionary period of 1981 to 1985.[1] To reverse the impact of the present recession, the business climate must be conducive to allow growth in the immediate future. SBSB encourages the government to provide tax credits, to allow full deductibility of health insurance premiums, and to provide relief from over 800 state mandated benefits which will help America's small businesses to compete fairly in our shrinking and evermore competitive marketplace.

Thank you.

[1] Birch, D.L.: *The Invisible Hand. Job Creation in America.* Collier-MacMillan, New York, 1987; pg. 16.

○